

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Estimate Package

2011-12 MAY REVISION



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DEPARTMENT OF PUBLIC HEALTH**

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1. FISCAL COMPARISON TABLES

Table 1a: Expenditure Comparison: FY 2010-11 in FY 2011-12 May Revision to FY 2010-11 Budget Act

	2010-11 in 2011-12 May Revision					2010 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	\$461,230	\$76,277	\$104,456	\$54,406	\$226,091	\$426,413		\$100,032	\$125,608	\$200,773	\$34,817	\$76,277	\$4,424	(\$71,202)	\$25,318
Drug Expenditure Estimate	\$459,098	\$76,277	\$104,456	\$54,406	\$223,958	\$424,280		\$100,032	\$125,608	\$198,640	\$34,817	\$76,277	\$4,424	(\$71,202)	\$25,318
Prescription Costs	\$445,233	\$73,973	\$101,302	\$52,763	\$217,195	\$414,286		\$96,931	\$121,714	\$195,641	\$30,947	\$73,973	\$4,371	(\$68,951)	\$21,554
Basic Prescription Costs	\$448,526	\$73,973	\$101,302	\$52,763	\$220,488	\$417,478		\$96,931	\$121,714	\$198,833	\$31,048	\$73,973	\$4,371	(\$68,951)	\$21,656
PBM Contract: Change in Reimburse. Rate															
True-Out-Of-Pocket Costs (HCR)	(\$3,294)				(\$3,294)	(\$3,192)				(\$3,192)	(\$102)				(\$102)
PBM Operational Costs	\$13,865	\$2,304	\$3,155	\$1,643	\$6,764	\$9,994		\$3,101	\$3,894	\$2,999	\$3,870	\$2,304	\$54	(\$2,251)	\$3,764
Basic PBM Costs	\$14,365	\$2,304	\$3,155	\$2,143	\$6,764	\$13,843		\$3,101	\$4,394	\$6,348	\$521	\$2,304	\$54	(\$2,251)	\$415
Administrative Reduction	(\$500)			(\$500)		(\$500)			(\$500)		\$			\$	
PBM Contract: Change in Transaction Fees						(\$3,349)				(\$3,349)	\$3,349				\$3,349
LHJ Administration	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Tropism Assay	\$133				\$133	\$133				\$133	\$				\$
Support/Administration Funding	\$2,485		\$1,178	\$411	\$896	\$2,657		\$1,178	\$411	\$1,068	(\$172)		\$	\$	(\$172)

Table 1b: Expenditure Comparison: FY 2010-11 in FY 2011-12 May Revision to FY 2010-11 in FY 2011-12 Governor's Budget (November Estimate)

	2010-11 in 2011-12 May Revision					2010-11 in 2011-12 Governor's Budget (November Estimate)					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	\$461,230	\$76,277	\$104,456	\$54,406	\$226,091	\$478,535	\$76,277	\$102,715	\$71,440	\$228,103	(\$17,305)	\$	\$1,741	(\$17,034)	(\$2,012)
Drug Expenditure Estimate	\$459,098	\$76,277	\$104,456	\$54,406	\$223,958	\$476,402	\$76,277	\$102,715	\$71,440	\$225,970	(\$17,305)	\$	\$1,741	(\$17,034)	(\$2,012)
Prescription Costs	\$445,233	\$73,973	\$101,302	\$52,763	\$217,195	\$462,015	\$73,973	\$99,613	\$69,283	\$219,146	(\$16,782)	\$	\$1,689	(\$16,520)	(\$1,951)
Basic Prescription Costs	\$448,526	\$73,973	\$101,302	\$52,763	\$220,488	\$465,434	\$73,973	\$99,613	\$69,283	\$222,565	(\$16,908)	\$	\$1,689	(\$16,520)	(\$2,077)
PBM Contract: Change in Reimburse. Rate															
True-Out-Of-Pocket Costs (HCR)	(\$3,294)				(\$3,294)	(\$3,420)				(\$3,420)	\$126				\$126
PBM Operational Costs	\$13,865	\$2,304	\$3,155	\$1,643	\$6,764	\$14,387	\$2,304	\$3,102	\$2,157	\$6,824	(\$523)	\$	\$53	(\$514)	(\$61)
Basic PBM Costs	\$14,365	\$2,304	\$3,155	\$2,143	\$6,764	\$14,887	\$2,304	\$3,102	\$2,657	\$6,824	(\$523)	\$	\$53	(\$514)	(\$61)
Administrative Reduction	(\$500)			(\$500)		(\$500)			(\$500)		\$			\$	
PBM Contract: Change in Transaction Fees															
LHJ Administration	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Tropism Assay	\$133				\$133	\$133				\$133	\$				\$
Support/Administration Funding	\$2,485		\$1,178	\$411	\$896	\$2,485		\$1,178	\$411	\$896	\$		\$	\$	\$

Table 1c: Expenditure Comparison: FY2011-12 May Revision to FY2010-11 in FY2011-12 May Revision

	2011-12 May Revision					2010-11 in 2011-12 May Revision					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	\$511,148	\$74,064	\$100,632	\$82,625	\$253,827	\$461,230	\$76,277	\$104,456	\$54,406	\$226,091	\$49,918	(\$2,213)	(\$3,824)	\$28,219	\$27,736
Drug Expenditure Estimate	\$503,620	\$74,064	\$100,632	\$82,625	\$246,299	\$459,098	\$76,277	\$104,456	\$54,406	\$223,958	\$44,522	(\$2,213)	(\$3,824)	\$28,219	\$22,340
Prescription Costs	\$496,526	\$73,036	\$99,235	\$81,479	\$242,776	\$445,233	\$73,973	\$101,302	\$52,763	\$217,195	\$51,293	(\$937)	(\$2,067)	\$28,716	\$25,581
Basic Prescription Costs	\$522,930	\$73,036	\$99,235	\$81,479	\$269,180	\$448,526	\$73,973	\$101,302	\$52,763	\$220,488	\$74,403	(\$937)	(\$2,067)	\$28,716	\$48,692
PBM Contract: Change in Reimburse Rate	(\$1,901)				(\$1,901)						(\$1,901)				(\$1,901)
PBM Contract: Change in Split Fee Rate	(\$1,336)				(\$1,336)						(\$1,336)				(\$1,336)
True-Out-Of-Pocket Costs (HCR)	(\$6,812)				(\$6,812)	(\$3,294)				(\$3,294)	(\$3,519)				(\$3,519)
Pre-Existing Condition Insurance Plan	(\$9,945)				(\$9,945)						(\$9,945)				(\$9,945)
Expansion of CARE/HIPP	(\$6,410)				(\$6,410)						(\$6,410)				(\$6,410)
PBM Operational Costs	\$7,094	\$1,028	\$1,397	\$1,146	\$3,523	\$13,865	\$2,304	\$3,155	\$1,643	\$6,764	(\$6,771)	(\$1,276)	(\$1,758)	(\$497)	(\$3,241)
Basic PBM Costs	\$15,209	\$2,204	\$2,995	\$2,458	\$7,553	\$14,365	\$2,304	\$3,155	\$2,143	\$6,764	\$845	(\$100)	(\$160)	\$315	\$789
Administrative Reduction						(\$500)				(\$500)	\$500				\$500
PBM Contract: Change in Transaction Fees	(\$8,115)	(\$1,176)	(\$1,598)	(\$1,311)	(\$4,030)						(\$8,115)	(\$1,176)	(\$1,598)	(\$1,311)	(\$4,030)
LHJ Administration	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: OA-PCIP	\$2,376				\$2,376						\$2,376				\$2,376
Premiums: CARE/HIPP	\$3,019				\$3,019						\$3,019				\$3,019
Tropism Assay	\$133				\$133	\$133				\$133	\$				\$
Support/Administration Funding	\$2,586		\$1,178	\$411	\$997	\$2,485		\$1,178	\$411	\$896	\$101		\$	\$	\$101

Table 1d: Expenditure Comparison: FY2011-12 May Revision to FY2011-12 in FY2011-12 Governor's Budget (November Estimate) with Conference Committee Decisions

	2011-12 May Revision					2011-12 Governor's Budget with Conference Committee Decisions					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Local Assistance Funding	\$511,148	\$74,064	\$100,632	\$82,625	\$253,827	\$531,304	\$70,000	\$100,632	\$103,665	\$257,007	(\$20,156)	\$4,064	\$	(\$21,040)	(\$3,180)
Drug Expenditure Estimate	\$503,620	\$74,064	\$100,632	\$82,625	\$246,299	\$529,171	\$70,000	\$100,632	\$103,665	\$254,874	(\$25,552)	\$4,064	\$	(\$21,040)	(\$8,576)
Prescription Costs	\$496,526	\$73,036	\$99,235	\$81,479	\$242,776	\$521,080	\$68,934	\$99,100	\$102,086	\$250,961	(\$24,555)	\$4,102	\$136	(\$20,608)	(\$8,185)
Basic Prescription Costs	\$522,930	\$73,036	\$99,235	\$81,479	\$269,180	\$529,922	\$68,934	\$99,100	\$102,086	\$259,803	(\$6,992)	\$4,102	\$136	(\$20,608)	\$9,377
PBM Contract: Change in Reimburse Rate	(\$1,901)				(\$1,901)	(\$1,927)				(\$1,927)	\$26				\$26
PBM Contract: Change in Split Fee Rate	(\$1,336)				(\$1,336)						(\$1,336)				(\$1,336)
True-Out-Of-Pocket Costs (HCR)	(\$6,812)				(\$6,812)	(\$6,915)				(\$6,915)	\$102				\$102
Client Cost Sharing											\$	\$	\$	\$	\$
Pre-Existing Condition Insurance Plan	(\$9,945)				(\$9,945)						(\$9,945)				(\$9,945)
Expansion of CARE/HIPP	(\$6,410)				(\$6,410)						(\$6,410)				(\$6,410)
PBM Operational Costs	\$7,094	\$1,028	\$1,397	\$1,146	\$3,523	\$8,091	\$1,066	\$1,532	\$1,579	\$3,914	(\$997)	(\$38)	(\$136)	(\$432)	(\$391)
Basic Prescription Costs	\$15,209	\$2,204	\$2,995	\$2,458	\$7,553	\$15,981	\$2,106	\$3,027	\$3,118	\$7,730	(\$772)	\$98	(\$32)	(\$660)	(\$177)
Administrative Reduction															
PBM Contract: Change in Transaction Fees	(\$8,115)	(\$1,176)	(\$1,598)	(\$1,311)	(\$4,030)	(\$7,890)	(\$1,040)	(\$1,494)	(\$1,539)	(\$3,816)	(\$225)	(\$136)	(\$104)	\$228	(\$214)
LHJ Administration	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: Medicare Part D	\$1,000				\$1,000	\$1,000				\$1,000	\$				\$
Premiums: OA-PCIP	\$2,376				\$2,376						\$2,376				\$2,376
Premiums: CARE/HIPP	\$3,019				\$3,019						\$3,019				\$3,019
Tropism Assay	\$133				\$133	\$133				\$133	\$				\$
Support/Administration Funding	\$2,586		\$1,178	\$411	\$997	\$2,586		\$1,178	\$411	\$997	\$		\$	\$	\$

TABLE 2a: Resource Comparison: FY 2010-11 in FY 2011-12 May Revision to FY 2010-11 Budget Act

	2010-11 in 2011-12 May Revision					2010-11 Budget Act					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	\$460,411	\$76,277	\$105,634	\$54,817	\$223,683	\$419,707		\$101,210	\$126,019	\$192,478	\$40,704	\$76,277	\$4,424	(\$71,202)	\$31,205
Basic Rebate Revenues	\$211,442				\$211,442	\$192,078				\$192,078	\$19,364				\$19,364
Income from Surplus Money Investments	\$300				\$300	\$400				\$400	(\$100)				(\$100)
Federal Funds	\$98,810		\$98,810			\$98,810		\$98,810			\$		\$		
General Funds	\$54,817			\$54,817		\$126,019			\$126,019		(\$71,202)			(\$71,202)	
Renegotiated Sup. Rebate/Price Freeze Agreements	\$352				\$352						\$352				\$352
Renegotiated Sup. Rebate/Price Freeze Agreements	\$11,589				\$11,589						\$11,589				\$11,589
One-Time Increase in FF 2009 Carryover (Section 28)	\$1,741		\$1,741								\$1,741		\$1,741		
One-Time Increase in FF RW Part B Supplemental	\$2,660		\$2,660								\$2,660		\$2,660		
One-Time Increase in FF RW Part B Shortfall Relief	\$2,423		\$2,423			\$2,400		\$2,400			\$23		\$23		
One-Time Increase from Safety Net Care Pool	\$76,277	\$76,277									\$76,277	\$76,277			

TABLE 2b: Resource Comparison: FY 2010-11 in FY 2011-12 May Revision to FY 2010-11 in FY 2011-12 Governor's Budget (November Estimate)

	2010-11 in 2011-12 May Revision					2010-11 in 2011-12 Governor's Budget (November Estimate)					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	\$460,411	\$76,277	\$105,634	\$54,817	\$223,683	\$478,120	\$76,277	\$103,893	\$71,851	\$226,099	(\$17,709)	\$	\$1,741	(\$17,034)	(\$2,416)
Basic Rebate Revenues	\$211,442				\$211,442	\$212,792				\$212,792	(\$1,349)				(\$1,349)
Income from Surplus Money Investments	\$300				\$300	\$300				\$300	\$				\$
Federal Funds	\$98,810		\$98,810			\$98,810		\$98,810			\$		\$		
General Funds	\$54,817			\$54,817		\$71,851			\$71,851		(\$17,034)			(\$17,034)	
Renegotiated Sup. Rebate/Price Freeze Agreements	\$352				\$352	\$352				\$352	\$				\$
Renegotiated Sup. Rebate/Price Freeze Agreements	\$11,589				\$11,589	\$12,656				\$12,656	(\$1,067)				(\$1,067)
One-Time Increase in FF 2009 Carryover (Section 28)	\$1,741		\$1,741								\$1,741		\$1,741		
One-Time Increase in FF RW Part B Supplemental	\$2,660		\$2,660			\$2,660		\$2,660			\$		\$		
One-Time Increase in FF RW Part B Shortfall Relief	\$2,423		\$2,423			\$2,423		\$2,423			\$		\$		
One-Time Increase from Safety Net Care Pool	\$76,277	\$76,277				\$76,277	\$76,277				\$	\$			

TABLE 2c: Resource Comparison: FY 2011-12 May Revision to FY 2010-11 in FY 2011-12 May Revision

	2011-12 May Revision					2010-11 in 2011-12 May Revision					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	\$514,745	\$74,064	\$101,810	\$83,036	\$255,835	\$460,411	\$76,277	\$105,634	\$54,817	\$223,683	\$54,334	(\$2,213)	(\$3,824)	\$28,219	\$32,152
Basic Rebate Revenues	\$230,444				\$230,444	\$211,442				\$211,442	\$19,002				\$19,002
Income from Surplus Money Investments	\$300				\$300	\$300				\$300	\$				\$
Federal Funds	\$98,810		\$98,810			\$98,810		\$98,810			\$				
General Funds	\$83,036			\$83,036		\$54,817			\$54,817		\$28,219			\$28,219	
Renegotiated Sup. Rebate/Price Freeze Agreements						\$352				\$352	(\$352)				(\$352)
Renegotiated Sup. Rebate/Price Freeze Agreements	\$26,616				\$26,616	\$11,589				\$11,589	\$15,028				\$15,028
Pre-Existing Condition Insurance Plan (PCIP)	(\$1,834)				(\$1,834)						(\$1,834)				(\$1,834)
Expansion of CARE/HIPP	\$309				\$309						\$309				\$309
One-Time Increase in FF 2009 Carryover (Section 28)						\$1,741		\$1,741			(\$1,741)		(\$1,741)		
One-Time Increase in FF RW Part B Supplemental						\$2,660		\$2,660			(\$2,660)		(\$2,660)		
One-Time Increase in FF RW Part B Shortfall Relief						\$2,423		\$2,423			(\$2,423)		(\$2,423)		
One-Time Anticipated Increase in FF RW Part B Supplemental 2011	\$3,000		\$3,000								\$3,000		\$3,000		
One-Time Increase from Safety Net Care Pool	\$74,064	\$74,064				\$76,277	\$76,277				(\$2,213)	(\$2,213)			

TABLE 2d: Resource Comparison: FY 2011-12 May Revision to FY 2011-12 in FY 2011-12 Governor's Budget (November Estimate) with Conference Committee Decisions

	2011-12 May Revision					2011-12 Governor's Budget with Conference Committee Decisions					Difference				
	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund	Total	Reimbursement	Federal	State	ADAP Special Fund
Available Resources	\$514,745	\$74,064	\$101,810	\$83,036	\$255,835	\$535,207	\$70,000	\$101,810	\$104,076	\$259,321	(\$20,463)	\$4,064	(\$)	(\$21,040)	(\$3,486)
Basic Rebate Revenues	\$230,444				\$230,444	\$232,202				\$232,202	(\$1,758)				(\$1,758)
Income from Surplus Money Investments	\$300				\$300	\$300				\$300	\$				\$
Federal Funds	\$98,810		\$98,810			\$98,810		\$98,810			(\$)		(\$)		
General Funds	\$83,036			\$83,036		\$104,076			\$104,076		(\$21,040)			(\$21,040)	
Renegotiated Sup. Rebate/Price Freeze Agreements															
Renegotiated Sup. Rebate/Price Freeze Agreements	\$26,616				\$26,616	\$26,819				\$26,819	(\$203)				(\$203)
Pre-Existing Condition Insurance Plan (PCIP)	(\$1,834)				(\$1,834)						(\$1,834)				(\$1,834)
Expansion of CARE/HIPP	\$309				\$309						\$309				\$309
One-Time Increase in FF 2009 Carryover (Section 28)															
One-Time Increase in FF RW Part B Supplemental															
One-Time Increase in FF RW Part B Shortfall Relief															
One-Time Anticipated Increase in FF RW Part B Supplemental 2011	\$3,000		\$3,000			\$3,000		\$3,000			\$		\$		
One-Time Increase from Safety Net Care Pool	\$74,064	\$74,064				\$70,000	\$70,000				\$4,064	\$4,064			

2. MAJOR ASSUMPTIONS

Estimate Methodology

Unadjusted expenditure estimates for the *May Revision 2011-12* estimate were derived from a linear regression model similar to that used in the *November Estimate* for FY 2010-11. The *May Revision 2011-12* model continued to include the two revisions from the *November Estimate* for FY 2010-11: first, 36 months of data were included in the model; second, data associated with claims from county jails were removed from the model. However, the 36-month data set for the *May Revision 2011-12* estimate used actual data from April 2008 through February 2011 and estimated March 2011 data, whereas the 36-month data set for the *November Estimate 2011-12* used data from August 2007 through July 2010.

The unadjusted revenue data set (January 2006 through March 2010 for the *November Estimate* and January 2006 through June 2010 for the *May Revision* data set) was used to estimate the revenue percent, which was applied to the revised, adjusted expenditure estimate for current and budget years.

For purposes of the *FY 2011-12 May Revision*, expenditure and revenue adjustments were made to the Fund Condition Statement (FCS) (Table 17, page 34) to reflect the estimated impact of two New, two Revised, three Continuing (assumption unchanged but fiscal outcome impacted by the revised expenditure estimate) and one Discontinued Major Assumptions, including:

New Assumptions

1. Pre-Existing Condition Insurance Plan (PCIP)
2. Expansion of the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment Program (CARE/HIPP)

Revised Assumptions

1. ADAP PBM Contract: Transaction Fees and Negotiated Pharmacy Discount Split Savings
2. One-Time Federal Funding through the Safety Net Care Pool

Unchanged Assumptions with Updated Fiscal Impact

1. Renegotiated Supplemental Rebate and/or Price Freeze Agreements
2. PBM Contract: Reduction in Reimbursement Rate
3. Legislation affecting Medicare Part D True Out of Pocket (TrOOP) Costs

Discontinued Assumptions

1. Expanded Share of Cost

The three remaining Major Assumptions from the *November Estimate 2011-12* were unchanged and did not have any updated fiscal impact:

Unchanged Assumptions without New Fiscal Impact

1. One-Time Increase in Federal Funds (#1): 2010 Ryan White Part B Supplemental Award (#2X08HA19011-02-00)
2. One-Time Increase in Federal Funds (#2): 2010 ADAP Shortfall Relief Award (#1X09HA20246-01-00)
3. Interest Earned

All of the final adjustments were added to or subtracted from the initial, unadjusted FY 2010-11 and FY 2011-12 expenditure and revenue estimates, respectively, to arrive at the final adjusted expenditure and revenue estimates.

New Major Assumptions

1. **MAJOR ASSUMPTION #1: Pre-Existing Condition Insurance Plan (OA-PCIP)** – The Patient Protection and Affordable Care Act authorizes PCIP to provide health insurance coverage to individuals who have been uninsured for six months due to a pre-existing condition. The California Department of Public Health (CDPH) Office of AIDS (OA) is developing a program to pay PCIP premiums for uninsured persons living with HIV/AIDS who are otherwise eligible for PCIP, including some existing ADAP clients. This new premium payment program will be called OA-PCIP. The Managed Risk Medical Insurance Board (MRMIB) administers California's PCIP and is working with OA on the implementation of OA-PCIP.

Clients who transition from "ADAP only" prescription drug coverage to OA-PCIP will benefit from full insurance coverage. Additionally, the net costs to the state will be lower than they would be if we maintained these clients in ADAP. OA does not intend to bill for 340B or voluntary supplemental rebates for individuals for whom it pays prescription-related out of pocket costs at this time as the current PCIP contract already includes negotiated manufacturer discounts at the Third-Party Administrator's PBM level.

Total Net Savings

With a July 1, 2011 implementation date and ramp-up throughout the fiscal year, OA estimated a total net savings in FY 2011-12 of \$5,735,157 consisting of:

- | | |
|---|---------------------|
| 1. Averted ADAP expenditures: | \$9,944,971 savings |
| 2. Rebate loss due to averted expenditures: | \$1,833,865 cost |
| 3. OA-PCIP premium costs: | \$2,375,949 cost |

Estimate Methodology

To estimate the FY 2011-12 net costs to OA of implementing this proposal, expenditures and revenue were computed for two components:

- Component 1 (Majority impact): Voluntary co-enrollment of an estimated 10 percent of ADAP-only clients into OA-PCIP; and
- Component 2 (Minor impact): Voluntary co-enrollment of any other HIV-infected PCIP clients who were not previously in ADAP into ADAP (to pay pharmaceutical deductibles and co-pays) and OA-PCIP.

General Approach: For Component 1, we hypothetically assumed the program was in place in *FY 2009-10* and estimated the final net costs to OA by applying the estimated percentage of ADAP costs derived from *FY 2009-10* data to the corresponding ADAP estimates for *FY 2011-12*. For Component 2, we estimated the final net costs to OA directly for *FY 2011-12* since PCIP was not in place in *FY 2009-10*. When combining components 1 and 2, we made adjustments to incorporate the ramp-up time needed to implement the new OA-PCIP in *FY 2011-12*. Note that rounded figures are provided in the text with the non-rounded estimates shown in the tables.

OA-PCIP Component 1*Step 1: Estimating FY 2009-10 Fiscal Impact*

To estimate OA-PCIP premium expenditures, we assumed that 10 percent of the ADAP-only clients who had been enrolled in ADAP for at least six months in FY 2009-10 and were U.S. legal residents would be eligible for and voluntarily enroll in OA-PCIP. We assumed that only 10 percent would choose to enroll in OA-PCIP because receiving care through OA-PCIP will result in new client out-of-pocket expenses (medical visit deductibles and co-pays for medical visits) that uninsured ADAP clients who receive care at Ryan White-funded clinics do not currently incur.

We multiplied this number of potential OA-PCIP enrollees from ADAP (n=1,010) by the current average age-adjusted annual cost of PCIP insurance premiums (\$4,482), resulting in an estimated annual premium cost of \$4.53 million. The annual cost of drug deductibles and co-pays for each OA-PCIP client is \$2,500 (the maximum allowable out-of-pocket costs for California PCIP clients) for a total cost of \$2.53 million. These clients would have incurred average annual ADAP drug expenditures of \$19,786 per client had they not enrolled in OA-PCIP. Therefore, enrolling them in OA-PCIP and deferring their full ADAP expenditures resulted in an estimated savings of \$19.99 million. Subtracting the annual premium cost of \$4.53 million and drug deductibles and co-pays of \$2.53 million from this \$19.99 million savings left an overall ADAP expenditure savings of \$12.93 million based on FY 2009-10 ADAP client and expenditure data.

There will be a net loss of rebate revenue, estimated to be the rebate that OA would have received from each new OA-PCIP client had they remained an ADAP-only client (31 percent of \$19,786 expenditures or \$6,134 in rebate). This \$6,134 in per client rebate loss was multiplied by 1,010 clients for a decrease in revenue of \$6.20 million.

In summary, the estimated net savings to ADAP based on FY 2009-10 ADAP data with full implementation of this component would be \$6.74 million (**Table 3**).

TABLE 3: ESTIMATED NET SAVINGS FOR <u>COMPONENT 1</u>, FY 2009-10				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,010	\$4,527,506	\$0	\$4,527,506
Drug Deductibles & Co-Pays	1,010	\$2,525,500	\$0	\$2,525,500
Averted Drug Expenditures	1,010	-\$19,987,817	-\$6,196,223	-\$13,791,594
TOTAL	1,010	-\$12,934,811	-\$6,196,223	-\$6,738,587
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

Step 2a: Estimating FY 2011-12 Fiscal Impact on Averted Drug Expenditures and Rebate – No Ramp Up

In order to use the FY 2009-10 ADAP estimated savings to estimate the savings in FY 2011-12, we examined the ADAP (averted drug expenditures and lost rebate) and OA-PCIP (premium and drug deductible and co-pay) costs/savings separately.

For ADAP averted drug expenditures, we computed the percent clients, percent expenditure savings, and percent rebate (of all clients, expenditures, and rebate) represented by these hypothetical OA-PCIP clients in FY 2009-10. These percentage estimates were then applied to the FY 2011-12 caseload, expenditure, and rebate estimates. **Table 4** shows the FY 2009-10 estimates, the FY 2009-10 percentages of the total, and the FY 2011-12 estimates derived by multiplying the FY 2009-10 percentages by the ADAP FY 2011-12 caseload, expenditure or rebate estimate. For clients, we divided the 1,010 total clients by the number of ADAP clients in FY 2009-10 (38,033), giving a result of 2.66 percent. For expenditure savings, we divided the \$19.99 million in ADAP savings by the \$413.04 million total expenditures in ADAP in FY 2009-10, which yielded 4.84 percent. For rebate revenue, we divided the \$6.20 million in rebate loss by the \$199.96 million total rebate in ADAP in FY 2009-10 for a 3.10 percentage. Applying these percentages to our FY 2011-12 estimates resulted in an OA-PCIP caseload of 1,131 (2.66 percent of 42,574), expenditure savings of \$25.16 million (4.84 percent of \$519.97 million), and rebate loss of \$7.80 million (3.10 percent of \$251.73 million). The FY 2011-12 estimated ADAP total was prior to adjusting for OA-PCIP and after adjusting for other assumptions with an expenditure impact. The FY 2011-12 estimated rebate revenue was calculated at the same rate as actual rebate in FY 2009-10 (\$199.96 million of \$413.04 million, or 48.41 percent).

TABLE 4: OA-PCIP AND ADAP CASELOAD, DRUG EXPENDITURE AND REBATE ESTIMATES FOR COMPONENT 1, FY 2011-12			
TIME PERIOD	CLIENTS	DRUG EXPENDITURES	REBATE REVENUE
FY 2009-10 ADAP Total	38,033	\$413,035,251	\$199,957,216
FY 2009-10 OA-PCIP Hypothetical	1,010	-\$19,987,817	-\$6,196,223
FY 2009-10 Percent	2.66%	-4.84%	-3.10%
FY 2011-12 Estimated ADAP Total	42,574	\$519,974,561	\$251,728,310
FY 2011-12 OA-PCIP Estimated	1,131	-\$25,162,880	-\$7,800,493
Negative (-) expend = savings and negative (-) revenue = rebate loss. FY 2011-12 Estimated ADAP Total is prior to adjusting for OA-PCIP.			

Step 2b: Estimating FY 2011-12 Fiscal Impact on Premiums, Drug Deductibles and Co-Pays – No Ramp Up

For OA-PCIP insurance premium costs, we used the annual age-adjusted OA-PCIP insurance premium cost (\$4,482, effective through December 2011) for both the FYs 2009-10 and 2011-12 estimates. We continued to use the existing PCIP premium cost for FY 2011-12 because no reliable data sources were available to suggest changes to the rates. We multiplied the annual premium estimate (\$4,482) by the estimated FY 2011-12 client count (1,131) to yield an estimated \$5.07 million in expenditures.

For drug expenditures associated with OA-PCIP deductibles and co-pays, we likewise assumed, given no data to the contrary, that the current \$2,500 maximum PCIP out-of-pocket limit would stay the same in FY 2011-12 and multiplied this by the estimated FY 2011-12 client count (1,131) to result in additional ADAP expenditures of \$2.83 million.

Step 2c: Estimating FY 2011-12 Fiscal Impact on Component 1 – No Ramp Up

Combining the ADAP averted drug expenditure and rebate estimates from Table 4 (Step 2a) with the impact on premiums, drug deductibles, and co-pays (Step 2b), the total net FY 2011-12 savings from Component 1 would be \$9.47 million, without taking into account ramp-up time (**Table 5**).

TABLE 5: ESTIMATED NET SAVINGS FOR COMPONENT 1, FY 2011-12 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,131	\$5,068,074	\$0	\$5,068,074
Drug Deductibles & Co-Pays	1,131	\$2,827,035	\$0	\$2,827,035
Averted Drug Expenditures	1,131	-\$25,162,880	-\$7,800,493	-\$17,362,387
TOTAL	1,131	-\$17,267,771	-\$7,800,493	-\$9,467,278
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

OA-PCIP Component 2*Step 1: Estimating FY 2011-12 Fiscal Impact – No Ramp Up*

We assumed that 1 percent of California PCIP slots would be taken by individuals with HIV/AIDS in FY 2011-12 who were not already enrolled in ADAP. The 1 percent estimate was a composite from three different sources (MRMIB, Medi-Cal, and OA Counseling and Testing data) providing a percent of individuals with HIV/AIDS in their respective populations. PCIP enrollment data from MRMIB show 1,410 enrollees at the end of January 2011, equaling approximately 300 enrollees per month from program implementation on October 25, 2010 thru January 2011. At this enrollment rate, we estimated nearly 3,000 slots will be filled on July 1, 2011. With an additional 3,600 new enrollees during FY 2011-12, we estimated a total of 6,600 subscribers on June 30, 2012. Of the projected 66 individuals in PCIP with HIV/AIDS who had not previously enrolled in ADAP (1 percent of 6,600), we assumed that 80 percent would voluntarily co-enroll in ADAP, yielding an estimated 53 clients. Our 80 percent estimate was based on the assumption that most clients already in PCIP would want to co-enroll in ADAP and OA-PCIP because this would mean that they would no longer have to pay PCIP premiums, drug deductibles, or co-pays. However, a few might opt not to enroll due to the administrative burden or the belief that those resources should be used by people with fewer resources, or they might not hear about the OA-PCIP program.

To estimate the annual OA-PCIP premium costs for these 53 clients, we multiplied 53 by the average age-adjusted annual cost of PCIP premiums (\$4,482), giving an estimated annual premium cost of \$236,639 (**Table 6**). The estimated drug deductible and co-pay cost to ADAP for these 53 new clients was derived by multiplying 53 by the annual PCIP out-of-pocket limit (\$2,500), for a total ADAP expenditure cost of \$132,000. No rebate revenue would be received on these 53 clients, nor would there be averted drug expenditures or a loss of rebate since these clients would be new to ADAP.

We estimated FY 2011-12 total expenditures to ADAP with full implementation of Component 2 to be \$368,639 (\$236,639 in OA-PCIP premium costs plus \$132,000 in ADAP drug expenditure costs for deductibles and co-pays with no rebate revenue).

TABLE 6: ESTIMATED NET COSTS FOR <u>COMPONENT 2</u>, FY 2011-12				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	53	\$236,639	\$0	\$236,639
Drug Deductibles & Co-Pays	53	\$132,000	\$0	\$132,000
Averted Drug Expenditures	0	\$0	\$0	\$0
TOTAL	53	\$368,639	\$0	\$368,639

Combining Components 1 and 2*Step 1: Estimating FY 2011-12 Fiscal Impact – No Ramp Up*

To estimate costs/savings in FY 2011-12, we added together the expenditures for OA-PCIP premiums (\$5.30 million, the sum of \$5.07 million from Table 5 and \$236,639 from Table 6) and drug deductibles and co-pays (\$2.96 million, the sum of \$2.83 million from Table 5 and \$132,000 from Table 6) with the ADAP averted drug expenditure savings of \$25.16 million from Table 5) for a total expenditure savings of \$16.90million shown in **Table 7**. Combining this with the loss of \$7.80 million in ADAP revenue resulted in a total net savings of \$9.10 million, assuming all clients were enrolled in ADAP and OA-PCIP on July 1, 2011. For total clients in FY 2011-12 (1,184), we added the clients from Components 1 (1,131) and 2 (53).

TABLE 7: <u>COMBINED COMPONENTS 1 AND 2</u>, FY 2011-12 ESTIMATE (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,184	\$5,304,713	\$0	\$5,304,713
Drug Deductibles & Co-Pays	1,184	\$2,959,035	\$0	\$2,959,035
Averted Drug Expenditures	1,131	-\$25,162,880	-\$7,800,493	-\$17,362,387
TOTAL	1,184	-\$16,899,132	-\$7,800,493	-\$9,098,639
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

Step 2: Estimating Final FY 2011-12 Fiscal Impact –Adjusting for Ramp Up

Our FY 2011-12 final cost/savings estimates employed the following method to determine the ramp-up rate:

1. Using FY 2009-10 ADAP expenditures, we examined the cumulative total by month to determine the increase in expenditures as the year progressed.
2. The cumulative total expenditures per month were converted to a cumulative percent. Since expenditures increased over time, the end of each three-month period did not exactly represent 25 percent, 50 percent, and 75 percent, respectively, of total expenditures.
3. The cumulative percent was converted to a “descending” cumulative percent to represent an entry point when clients enroll. If all clients enrolled on July 1, 2011, they would yield the full \$9.10 million in savings (100 percent), but if all clients enrolled on October 1, 2011 they would yield 76.15 percent of the \$9.10 million in savings (100 percent minus the 23.85 percent estimated to be received in the three months prior to that enrollment).
4. The net annual savings realized by OA was calculated by taking into account the month when all clients enrolled.
5. Knowing that a new program would not be fully implemented on the first day, and that the 1,184 clients would gradually enroll during the year, a ramp-up methodology was applied. The “5-28-33-33” percent ramp-up rate assumed a slow transition period in the first quarter (since it would take clients time to find out about and apply for this brand new program), a faster transition period in the second quarter, and the most efficient transition in the last two quarters. Final savings in FY 2011-12 were estimated to be \$5,735,157. In addition, for purposes of the FCS, the ramp-up methodology described above computed separately premiums, drug expenditures, and rebate revenue for the net savings of \$5,735,157.

Operational and Administrative Considerations

By working collaboratively with MRMIB and OA's key stakeholders, OA will develop and implement protocols for the new OA-PCIP program. OA will work with current CARE/HIPP and ADAP enrollment workers to expand their services to PCIP enrollment. OA will also work towards providing a centralized OA-PCIP enrollment option, allowing clients to apply directly to OA-PCIP. OA will collect client applications from enrollment workers or directly from clients, process the applications and submit them to MRMIB. After processing the applications, MRMIB will identify these clients as OA-PCIP clients and bill both the client and ADAP directly. MRMIB's PCIP database will be updated to create an OA-PCIP identifier and a billing file that will allow MRMIB to transmit pertinent billing data to OA. OA staff will update the AIDS Regional Information and Evaluation System (ARIES) to track OA-PCIP clients and insurance premium information.

OA will also provide comprehensive outreach and education activities for the new OA-PCIP program. OA will develop and conduct outreach and education/training for local health jurisdictions (LHJs), healthcare providers, community-based benefits counselors, and ADAP and CARE/HIPP enrollment workers. OA will collaborate with key stakeholders to identify additional outreach audiences, create marketing materials, and disseminate information.

OA will utilize existing budgeted positions during FY 2011-12 to initially implement OA-PCIP. Since much of the OA-PCIP policy, and thus impact on program workload, is still being defined, OA will address any potential unbudgeted workload increases in future budget processes.

2. **MAJOR ASSUMPTION #2:** Expansion of CARE/HIPP– CARE/HIPP was originally established to pay health insurance premiums on behalf of individuals disabled as a result of HIV/AIDS who were at risk of losing their Consolidated Omnibus Budget Reconciliation Act covered health insurance. The program was designed at that time to bridge the gap between an individual losing employment due to AIDS-related disability and the availability of publicly funded health coverage through Medicare or Medi-Cal. Currently, individuals are eligible for a lifetime maximum of 36 months of coverage if they are a California resident, are disabled by HIV/AIDS, have assets less than \$6,000, have income less than 400 percent Federal Poverty Level (FPL), have monthly health insurance premiums less than \$700 and have private health insurance with prescription drug coverage.

OA is expanding eligibility requirements and extending the coverage period for CARE/HIPP to make this program available to more individuals with health insurance who are at risk of losing it and to individuals currently without health insurance who would like to purchase health insurance. Each client that enrolls in CARE/HIPP is associated with savings in ADAP as insurance premium payments are less expensive than full ADAP coverage. Also, ADAP can bill for rebates for CARE/HIPP clients who are co-enrolled in ADAP for payment of pharmaceutical co-pays. CARE/HIPP expansion will result in an overall decrease in ADAP expenditures and GF need while providing more comprehensive insurance coverage to people living with HIV/AIDS.

Total Net Savings

With a July 1, 2011 implementation date and ramp-up throughout the fiscal year, OA estimated a total net savings in FY 2011-12 of \$3,698,975 consisting of:

- | | |
|---|---------------------|
| 1. Averted ADAP expenditures: | \$6,409,898 savings |
| 2. Net rebate gain (including rebate loss due to averted expenditures of \$1,236,069, and rebate gain from co-enrollment in ADAP of \$1,544,579): | \$308,510 savings |
| 3. CARE/HIPP premium costs: | \$3,019,433 cost |

Estimate Methodology

The cost-savings estimate related to the proposed CARE/HIPP expansion was based on expected caseload changes and associated savings using both CARE/HIPP and ADAP data from FY 2009-10 projected forward to FY 2011-12. CARE/HIPP expansion includes:

- Component 1: Expanding eligibility to include clients without an HIV-related disability;
- Component 2: Expanding eligibility by allowing clients to remain on the program as long as the services are needed;
- Component 3: Expanding eligibility by including cost effective insurance premiums for eligible clients;
- Component 4: Expanding eligibility by using financial eligibility requirements as defined in state statute for ADAP; and
- Component 5: Facilitating co-enrollment of eligible CARE/HIPP clients in ADAP.

General steps: For each component, we hypothetically assumed the component was in place in *FY 2009-10* (step 1) and then estimated the final FY 2011-12 net costs to OA by applying the estimated percentage of ADAP costs derived from FY 2009-10 data to the corresponding ADAP estimates for *FY 2011-12* (step 2). Adjustments were made to incorporate the *ramp-up time* (step 3) needed to implement CARE/HIPP expansion in FY 2011-12. Note that rounded figures are provided in the text with non-rounded estimates shown in the tables.

Step 1: Estimating FY 2009-10 Fiscal Impact**CARE/HIPP Component 1 - Expanding eligibility to include clients not disabled by HIV/AIDS**

For Component 1, OA examined its database of clients receiving OA-funded care services and, among these, clients not already in CARE/HIPP. Sixteen percent of these clients have private insurance and are disabled due to HIV/AIDS. OA divided the number of CARE/HIPP clients in FY 2009-10 (n=253) by 16 percent to estimate the potential total number of clients that might enter the program if the disability requirement were eliminated (1,591), and then subtracted the most recent number of clients served (253) to estimate the total additional number of clients who might be served (1,338). To estimate expenditures, OA then multiplied the result by the average annual CARE/HIPP cost in FY 2009-10 (\$3,310) for an estimated annual premium expenditure of \$4.43 million.

To estimate the fiscal impact on ADAP (drug deductibles and co-pays with associated rebate and averted drug expenditures with associated rebate) resulting from CARE/HIPP expansion due to an increase of non-disabled clients, we first had to estimate the increase in ADAP caseload for three distinct groups of clients:

- Group 1: New co-enrolled ADAP clients resulting from CARE/HIPP expansion;
- Group 2: New clients to CARE/HIPP who do not co-enroll in ADAP; and
- Group 3: New clients to CARE/HIPP who are already enrolled in ADAP with private insurance.

Group 1. Fifty-one percent of existing CARE/HIPP clients were already voluntarily enrolled in ADAP with private insurance at some time in FY 2009-10. According to data from the Centers for Disease Control and Prevention (CDC)-sponsored Medical Monitoring Project (MMP), a representative sample of HIV-infected people in care in California, an estimated 23 percent of HIV-infected individuals in care in California with private insurance are also co-enrolled in ADAP. These percentages were applied to determine the number of new CARE/HIPP clients we estimate would also voluntarily co-enroll in ADAP. Applying these percentages to the new CARE/HIPP clients [(1,338 X 51 percent) – (1,338 X 23 percent)] resulted in 378 new ADAP clients from the CARE/HIPP expansion.

The expenditure estimate for deductibles and co-pays for new CARE/HIPP clients who would also be new ADAP clients was derived by multiplying the number of new ADAP clients (n=378) by the average ADAP cost for a current CARE/HIPP client in ADAP (\$1,748), leading to a total annual cost of \$660,992. Had they not enrolled in CARE/HIPP, 50 percent of these clients would have become expensive ADAP-only clients, incurring average annual per person ADAP drug expenditures of \$14,940 for an estimated annual savings of \$2,824,718. Final expenditure savings for Component 1 in FY 2009-10 for Group 1 were computed by subtracting \$660,992 in expenditures from \$2.82 million in expenditure savings for a savings of \$2,163,726.

Net change in rebate was calculated for new ADAP clients from CARE/HIPP expansion (248 percent of \$660,992 expenditures, or \$1,639,259 in rebate) and subtracting rebate loss had they remained ADAP-only clients (31 percent of \$2.82 million, or \$875,663 in rebate) for an overall net gain in rebate of \$763,597. Therefore, the Component 1 net savings to ADAP for Group 1 based on FY 2009-10 were estimated to be \$2,927,323 (\$2,163,726 in expenditure savings plus \$763,597 in additional rebate).

Group 2. Since 51 percent of new CARE/HIPP clients were estimated to voluntarily enroll in ADAP based on FY 2009-10 data, 49 percent (1,338 X 49 percent or 651 clients) are estimated not co-enroll; if these new CARE/HIPP clients did not enroll in ADAP then there would be no drug deductible and co-pay expenditures associated with this component. However, without CARE/HIPP expansion, 50 percent of these clients would presumably lose their private insurance, become ADAP-only clients, and would have incurred average annual ADAP drug expenditures of \$14,940 for an estimated annual savings of \$4,859,869 in averted drug expenditures for these clients.

Thirty-one percent rebate revenue for these averted drug expenditures resulted in a rebate loss of \$1,506,559. In sum, Component 1 savings for new Group 2 CARE/HIPP clients who do not co-enroll in ADAP would be \$3,353,310 (\$4,859,869 in deductibles and co-pays – \$1,506,559 in lost rebate).

Group 3. The final potential new CARE/HIPP group is the 309 clients who are already in ADAP, currently with private insurance, and potentially at risk of losing this insurance (23 percent of 1,338). Change in expenditures for drug deductibles and co-pays for these clients was calculated as the difference between the average cost of a CARE/HIPP client in ADAP (\$1,748) and the average cost of a non-CARE/HIPP, private insurance client in ADAP (\$2,406) for a total estimated annual savings of \$203,630.

Without CARE/HIPP expansion, 50 percent of these clients would presumably lose their private insurance benefits and become ADAP-only clients. Thus, their averted drug expenditures would be \$14,940 per client for a total estimated annual savings of \$2,311,729.

At a 248 percent rebate rate for private insurance clients in ADAP, the rebate loss associated with the \$203,630 in deductibles and co-pays would be \$505,003. At a 31 percent ADAP-only rebate rate, the rebate loss associated with the \$2.31 million in averted drug expenditures would be \$716,636. Combining both losses resulted in total rebate loss of \$1,221,639. Overall, the Group 3 savings for Component 1 in FY 2009-10 would be \$1,293,720 = [(\$203,630 – \$505,003) + (\$2,311,729 – \$716,636)].

Group Total. **Table 8** summarizes the analyses above for premiums, drug deductibles and co-pays, and averted drug expenditures for the new CARE/HIPP clients and their impact on ADAP. The estimated expenditure savings of \$5.11 million coupled with a rebate loss of \$1.96 million resulted in an estimated savings of \$3.14 million for Component 1 in FY 2009-10.

TABLE 8: ESTIMATED NET SAVINGS FOR <u>COMPONENT 1</u>, FY 2009-10 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,338	\$4,430,055	\$0	\$4,430,055
Drug Deductibles & Co-Pays	688	\$457,361	\$1,134,256	-\$676,895
Averted Drug Expenditures	669	-\$9,996,316	-\$3,098,858	-\$6,897,458
TOTAL	1,338	-\$5,108,900	-\$1,964,602	-\$3,144,298
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

CARE/HIPP Component 2 - Expanding eligibility by allowing clients to remain in CARE/HIPP

For Component 2, the number of clients who were disenrolled from CARE/HIPP between July 2009 and June 2010 with a reason of “36 months exhausted” (n=12) was multiplied by each client’s average monthly premium cost. The number of months beyond his/her disenrollment date in CARE/HIPP until the end of FY 2009-2010 were then counted and multiplied by the client’s average monthly cost, for each client. These per-client cost estimates for CARE/HIPP expansion expenditures were then summed for an additional total premium cost of \$108,148.

Of the 12 CARE/HIPP clients who exhausted their eligibility, six were co-enrolled in ADAP with private insurance after losing their CARE/HIPP coverage. Based on actual data for co-enrolled ADAP and CARE/HIPP clients in FY2009-10, we estimate savings in drug deductibles and co-pays if they changed from being a private insurance client in ADAP (\$2,406 per year) to a CARE/HIPP client in ADAP (\$1,748 per year) for a total estimated annual savings of \$3,948.

The loss in rebate would be 248 percent of expenditures for deductibles and co-pays for a private insurance client in ADAP (\$5,967 rebate loss per client) subtracted from the 248 percent rebate for expenditures as a CARE/HIPP client in ADAP (\$4,335 rebate loss per client) for a total rebate loss of \$9,791 [(\$5,967 - \$4,335) x 6 clients]. Since the remaining six clients who exhausted their CARE/HIPP eligibility were not enrolled in ADAP at all in FY 2009-10, there would be no averted drug expenditures and its associated rebate.

Table 9 displays the estimated changes in premiums, drug deductibles, and co-pays, and rebate loss as a result of Component 2, resulting in a net cost of \$113,991.

TABLE 9: ESTIMATED NET COSTS FOR <u>COMPONENT 2</u>, FY 2009-10 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	12	\$108,148	\$0	\$108,148
Drug Deductibles & Co-Pays	6	-\$3,948	-\$9,791	\$5,843
Averted Drug Expenditures	0	\$0	\$0	\$0
TOTAL	12	\$104,200	-\$9,791	\$113,991
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

CARE/HIPP Component 3 - Expanding eligibility by including clients with cost-effective premiums

Currently, CARE/HIPP has an individual monthly premium limit of \$700. An Internet search did not identify any private insurance group plans with monthly premiums above \$700, but an informal phone survey suggested a few individual insurance carriers might provide coverage for an HIV-infected person and would charge a higher premium. Information from advocates also indicated that there are clients who are turned away because their premium rates exceed the CARE/HIPP premium limit. To estimate the fiscal impact of expanding CARE/HIPP eligibility by including payment of all cost effective insurance premiums for eligible clients, we assumed a conservative 2 percent of potential CARE/HIPP clients are currently denied enrollment due to premiums in excess of \$700 per month (n=5, or 2 percent of 253). Our informal phone survey found monthly premiums in the \$750 to \$800 range for an HIV-infected male in the 45 year old age group on antiretroviral drug therapy. As a result, considering older age groups with even higher premiums, we assumed a 20 percent increase above the current limit of \$700 for a monthly premium of \$840 for this population. The estimated number of new CARE/HIPP clients (n=5) was multiplied by our estimated monthly premium cost for this population (\$840) and then by 12 months for estimated annual premiums of \$51,005.

Based on FY 2009-10 data and applying a 51 percent co-enrollment rate, three of these five new CARE/HIPP clients would also enroll in ADAP and thus have additional drug deductible and co-pay expenditures. Multiplying these three clients by the annual cost of a CARE/HIPP client in ADAP (\$1,748) resulted in annual estimated expenditures of \$4,544 on drug deductibles and co-pays. Savings would be achieved from averted drug expenditures if 50 percent of the five clients new to CARE/HIPP were instead ADAP-only clients (\$14,940) for total estimated annual savings of \$37,798.

Rebate associated with the drug deductibles and co-pays was 248 percent of \$4,544 for additional rebate revenue of \$11,270. But this rebate was offset by the loss in rebate associated with the averted drug expenditures at 31 percent of \$37,798 for a rebate loss of \$11,717. Adding together the various line items for expenditures and rebate revenue resulted in a net cost of \$18,198 for Component 3 in FY 2009-10 (**Table 10**).

TABLE 10: ESTIMATED NET COSTS FOR <u>COMPONENT 3</u>, FY 2009-10 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	5	\$51,005	\$0	\$51,005
Drug Deductibles & Co-Pays	3	\$4,544	\$11,270	-\$6,726
Averted Drug Expenditures	3	-\$37,798	-\$11,717	-\$26,081
TOTAL	5	\$17,751	-\$447	\$18,198

CARE/HIPP Component 4 - Expanding eligibility to mirror ADAP eligibility

Expanding CARE/HIPP eligibility to mirror ADAP eligibility would increase the CARE/HIPP income limit from 400 FPL (which in FY 2009-10 was \$43,320) to \$50,000 and eliminate the CARE/HIPP \$6,000 asset test, which excludes homes and vehicles. In FY 2009-10, 3.74 percent of ADAP clients with private insurance had incomes between 400 percent FPL and \$50,000. No data were available to estimate how many clients would be eligible for CARE/HIPP because of the removal of the asset test, so an arbitrary additional 1.26 percent of clients was used which, when added to the 3.74 percent of clients added because of the income change, resulted in an estimated 5 percent increase in CARE/HIPP clients due to Component 4.

Line item expenditures and rebate for Component 4 were computed in the same manner as Component 3. Thirteen new CARE/HIPP clients (5 percent of 253) were multiplied by the annual premium for a CARE/HIPP client (\$3,310) for estimated annual premiums of \$41,877.

Drug deductibles and co-pays for the estimated 51 percent of these 13 clients who would co-enroll in ADAP (6 clients) at \$1,748 per client resulted in total annual expenditures of \$11,361.

The averted drug expenditures or savings from enrolling 50 percent of the 13 clients in CARE/HIPP instead of having no insurance and becoming ADAP-only clients resulted in a total annual savings of \$94,496 (6 clients at \$14,940 per client).

Rebate associated with drug deductibles and co-pays at 248 percent (\$28,176) was offset by the rebate loss from averted drug expenditures at 31 percent (\$29,294). Net savings from summing the various expenditure and rebate line items resulted in savings of \$40,139 from Component 4 (**Table 11**).

TABLE 11: ESTIMATED NET SAVING FOR COMPONENT 4, FY 2009-10 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	13	\$41,877	\$0	\$41,877
Drug Deductibles & Co-Pays	6	\$11,361	\$28,176	-\$16,815
Averted Drug Expenditures	6	-\$94,496	-\$29,294	-\$65,202
TOTAL	13	-\$41,257	-\$1,118	-\$40,139
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

CARE/HIPP Component 5 - Facilitating co-enrollment into ADAP

To estimate the net costs/savings of facilitating co-enrollment of current CARE/HIPP clients into ADAP who are not already in ADAP, we assumed that 90 percent of current CARE/HIPP clients would co-enroll in ADAP if we facilitated this co-enrollment. Since 169 out of 253 CARE/HIPP clients were already co-enrolled in ADAP in FY 2009-10, the number of new ADAP clients resulting from this proposal if it had been implemented in FY 2009-10 would be 76 (90 percent of 253 – 169). The 169 existing dually-enrolled clients would not result in any new expenditures or rebate revenue from ADAP if this proposal were implemented.

Additional expenditures for the 76 new ADAP clients were derived by multiplying this number by the average annual cost of a CARE/HIPP client in ADAP (\$1,748) for an estimated total of \$132,149. New ADAP savings would include rebate revenue for these expenditures at a collection rate of 248 percent for an estimated total of \$327,729. The resulting annual net savings to ADAP, expenditures minus rebate, would be \$195,580 (**Table 12**).

Since these 76 clients are already enrolled in CARE/HIPP, there would be no additional premium costs. There would be no averted drug expenditures for these clients since this enhancement component does not impact a client's eligibility to enroll in CARE/HIPP.

TABLE 12: ESTIMATED NET SAVINGS FOR <u>COMPONENT 5</u>, FY 2009-10 (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	0	\$0	\$0	\$0
Drug Deductibles & Co-Pays	76	\$132,149	\$327,729	-\$195,580
Averted Drug Expenditures	0	\$0	\$0	\$0
TOTAL	76	\$132,149	\$327,729	-\$195,580
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

Combining Components 1 through 5

The total ADAP costs and savings for implementing the package with all five components were calculated by estimating the combined number of total clients associated with the CARE/HIPP expansion. Once the number of clients was estimated, premiums, expenditures, and rebate were then calculated by multiplying their respective average annual figures with the adjusted number of clients. The combined calculation assumed all components were implemented at the beginning of the FY.

The number of clients could not simply be summed across the five components because of the interaction between the components. For example, in Component 5 we assumed that 90 percent of CARE/HIPP clients would co-enroll in ADAP, so when combined with Component 1, 90 percent (rather than 51 percent) of the new non-disabled CARE/HIPP clients who were not already in ADAP would co-enroll in ADAP. Similarly, for Component 3 we added in 2 percent of the new 1,338 clients from Component 1, 12 from Component 2, and 13 from Component 4 in addition to the 2 percent of the 253 FY 2009-10 CARE/HIPP clients. Similarly for Component 4 we added in 5 percent of the new 1,338 clients from Component 1, 12 from Component 2, and 5 from Component 3 in addition to the 5 percent of the 253 FY 2009-10 CARE/HIPP clients. For Component 5 we also then assumed that 90 percent of the new CARE/HIPP clients from Components 2, 3, and 4 who were not already co-enrolled in ADAP also co-enrolled. We then summed the adjusted client counts across all components and calculated expenditures and rebate revenue as above.

Adjusting, multiplying and summing the five components resulted in estimated expenditure savings of \$4.01 million with \$838,251 in additional rebate, for a net savings of \$4.85 million in FY 2009-10 (**Table 13**). Total estimated number of clients in CARE/HIPP was 1,463 with an estimated 1,402 co-enrolled in ADAP.

TABLE 13: COMBINED COMPONENTS 1 THROUGH 5, FY 2009-10 ESTIMATE (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,463	\$5,130,161	\$0	\$5,130,161
Drug Deductibles & Co-Pays	1,402	\$1,692,245	\$4,196,768	-\$2,504,523
Averted Drug Expenditures	725	-\$10,833,925	-\$3,358,517	-\$7,475,408
TOTAL	1,463	-\$4,011,519	\$838,251	-\$4,849,770
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

Step 2: Estimating FY 2011-12 Fiscal Impact– No Ramp Up

In order to use the FY 2009-10 ADAP estimated savings to estimate the savings in FY 2011-12, we examined the ADAP (drug deductibles and co-pays and averted drug expenditures with rebate) and CARE/HIPP (premium) costs/savings separately.

For drug deductibles and co-pays, we computed the percent clients, percent expenditure and percent rebate (of all clients, expenditures and rebate) represented by these hypothetical ADAP clients in FY 2009-10. These percentage estimates were then applied to the FY 2011-12 caseload, expenditure, and rebate estimates. **Table 14** shows the FY 2009-10 estimates, the FY 2009-10 percentages of the total, and the FY 2011-12 estimates derived by multiplying the FY 2009-10 percentages by the ADAP FY 2011-12 caseload, expenditure or rebate estimate. For clients, we divided the 1,402 clients for whom ADAP would pay drug deductibles and co-pays by the number of ADAP clients in FY 2009-10 (38,033), giving a result of 3.69 percent. For expenditure, we divided the \$1.69 million in ADAP expenditures by the \$413.04 million total expenditures in ADAP in FY 2009-10, which yielded 0.41 percent. For rebate revenue, we divided the \$4.20 million in rebate loss by the \$199.96 million total rebate in ADAP in FY 2009-10 for a 2.10 percentage. Applying these percentages to our FY 2011-12 estimates resulted in 1,570 clients for whom ADAP would pay drug deductibles and co-pays (3.69 percent of 42,574), expenditures of \$2.13 million (0.41 percent of \$519.74 million), and rebate gain of \$5.28 million (2.10 percent of \$251.73 million). The FY 2011-12 estimated ADAP total was prior to adjusting for both CARE/HIPP expansion and OA-PCIP and after adjusting for other assumptions with an expenditure impact. The FY 2011-12 estimated rebate revenue was calculated at the same rate as actual rebate in FY 2009-10 (\$199.96 million of \$413.04 million, or 48.41 percent).

TABLE 14: CARE/HIPP and ADAP CASELOAD, DRUG DEDUCTIBLES AND COPAY EXPENDITURES, AND REBATE ESTIMATES, FY 2011-12 (Prior to Adjusting for Ramp-Up)			
TIME PERIOD	CLIENTS	DRUG DEDUCTIBLES AND COPAY EXPENDITURES	REBATE REVENUE
FY 2009-10 ADAP Total	38,033	\$413,035,251	\$199,957,216
FY 2009-10 ADAP Hypothetical	1,402	\$1,692,245	\$4,196,768
FY 2009-10 Percent	3.69%	0.41%	2.10%
FY 2011-12 Estimated ADAP Total	42,574	\$519,974,561	\$251,728,310
FY 2011-12 ADAP Estimated	1,570	\$2,130,386	\$5,283,356
Negative (-) expend = savings and negative (-) revenue = rebate loss. FY 2011-12 Estimated ADAP Total is prior to adjusting for CARE-HIPP Expansion and OA-PCIP.			

Averted drug expenditures, associated rebate and the number of clients with these averted expenditures for FY 2011-12 were computed in the same manner as drug deductibles and co-pays described above. By applying the FY 2009-10 percentages to FY 2011-12 estimates, there would be \$13.64 million in expenditure savings with \$4.23 million in loss rebate (**Table 15**).

TABLE 15: ADAP CASELOAD, AVERTED DRUG EXPENDITURES, AND REBATE ESTIMATES, FY 2011-12 (Prior to Adjusting for Ramp-Up)			
TIME PERIOD	CLIENTS	AVERTED DRUG EXPENDITURES	REBATE REVENUE
FY 2009-10 ADAP Total	38,033	\$413,035,251	\$199,957,216
FY 2009-10 ADAP Hypothetical	725	-\$10,833,925	-\$3,358,517
FY 2009-10 Percent	1.91%	-2.62%	-1.68%
FY 2011-12 Estimated ADAP Total	42,574	\$519,974,561	\$251,728,310
FY 2011-12 ADAP Estimated	812	-\$13,638,946	-\$4,228,073
Negative (-) expend = savings and negative (-) revenue = rebate loss. FY 2011-12 Estimated ADAP Total is prior to adjusting for CARE-HIPP Expansion and OA-PCIP.			

For CARE/HIPP premiums, we estimated new clients by applying the FY 2009-10 percent ($1,463 / 38,033 = 3.85$ percent) to the FY 2011-12 estimate (42,574) for a total client caseload of 1,638. Annual CARE/HIPP premiums remained at the FY 2009-10 average of \$3,310, because the three-year average change from FY 2007-08 through FY 2009-10 was -0.06 percent. Thus, \$3,310 annual premiums for 1,638 clients yielded \$5.42 million in expenditures.

Final full-year estimates for FY 2011-12 were derived by summing up the individual line items for total expenditure savings of \$6.09 million with a rebate increase of \$1.06 million for a final net savings of \$7.14 million. Total clients (1,638) indicates the total number of new CARE/HIPP clients, but only 1,570 of these clients would be co-enrolled in ADAP (**Table 16**).

TABLE 16: COMBINED COMPONENTS 1 THROUGH 5 SUMMARY, FY 2011-12 ESTIMATE (Prior to Adjusting for Ramp-Up)				
LINE ITEM	CLIENTS	EXPENDITURES	REBATE REVENUE	NET
Premiums	1,638	\$5,421,198	\$0	\$5,421,198
Drug Deductibles & Co-Pays	1,570	\$2,130,386	\$5,283,356	-\$3,152,971
Averted Drug Expenditures	812	-\$13,638,946	-\$4,228,073	-\$9,410,872
TOTAL	1,638	-\$6,087,362	\$1,055,283	-\$7,142,645
Negative (-) expend and (-) net = savings; and negative (-) revenue = rebate loss.				

Step 3: Estimating FY 2011-12 Fiscal Impact –Adjusting for Ramp Up

Our FY 2011-12 final cost/savings estimates employed the following methods to determine the ramp-up rate:

1. Using FY 2009-10 ADAP expenditures, we examined the cumulative total by month to determine the increase in expenditures as the year progressed.
2. The cumulative total expenditures per month were converted to a cumulative percent. Since expenditures increased over time, the end of each three month periods did not exactly represent 25 percent, 50 percent, and 75 percent, respectively, of total expenditures.
3. The cumulative percent was converted to a “descending” cumulative percent to represent an entry point when clients enroll. If all clients enrolled on July 1, 2011, they would yield the full \$7.14 million in savings (100 percent), but if all clients enrolled on October 1, 2011 they would yield 76.15 percent of the \$7.14 million in savings (100 percent minus the 23.85 percent estimated to be received in the three months prior to that enrollment).
4. The net annual savings realized by OA was calculated by taking into account the month when all clients enrolled.
5. Knowing that CARE/HIPP expansion would not be fully implemented on the first day, and that the 1,570 clients would gradually enroll during the year, a ramp-up methodology was applied. The “25-25-25-25” percent ramp-up rate assumed an even transition period throughout the year. Final savings in FY 2011-12 were estimated to be \$3,698,975. In addition, for purposes of the FCS, the ramp-up methodology described above computed separately premiums (\$3,019,433), drug expenditures (-\$6,409,898), and rebate revenue (\$308,510) for the net savings of \$3,698,975.

Operational and Administrative Considerations

Currently, staff process annual applications and quarterly re-certifications submitted by enrollment workers and track client files in the ARIES database. Similar to OA-PCIP, OA will work towards providing a centralized CARE/HIPP enrollment option, allowing clients to apply directly to CARE/HIPP. In addition to individuals in jeopardy of losing their health insurance, OA anticipates receiving applications from individuals currently without health insurance who would like to purchase health insurance.

Determining CARE/HIPP and PCIP Eligibility

When assessing a CARE/HIPP application from an individual that is not eligible for PCIP, OA will determine if the proposed premium rate is lower than the relevant threshold. If so, the client will be enrolled in CARE/HIPP and receive full funding of their premium. If the premium rate is higher than the relevant threshold, OA will offer to pay up to the threshold amount, leaving the balance to be paid by the client.

When assessing a CARE/HIPP application from an individual that is eligible for PCIP, OA will assist them in applying for PCIP and OA-PCIP. However, if the applicant has indicated they have access to an insurance product with a premium rate that is lower than the PCIP premium rate for their individual circumstances (based upon their age and location), the applicant will be evaluated for potential enrollment in CARE/HIPP.

Determining Premium Thresholds

Federal Ryan White law requires CARE/HIPP premium payments to be cost effective or cost neutral. To determine a cost threshold under which an insurance premium would be cost effective, two types of applicants must be considered:

- Applicants not eligible for PCIP (currently with insurance or have been without insurance for less than six months or otherwise not meeting PCIP eligibility requirements); and
- Applicants eligible for PCIP (not having had insurance for at least six months and meeting other eligibility requirements).

Two cost thresholds were identified for applicants not eligible for PCIP, based upon status of co-enrollment in ADAP:

- Individuals that are co-enrolled in ADAP – The cost threshold would be **\$1,938**, the average monthly cost of a 100% ADAP client.
- Individuals that are not enrolled in ADAP – The cost threshold would be **\$1,337**, the average monthly cost of a 100% ADAP client minus the average monthly rebate revenue (net cost).

Two cost thresholds were also identified for applicants eligible for PCIP who elect to enroll in CARE/HIPP rather than OA-PCIP, based upon status of co-enrollment in ADAP (see MRMIB website for PCIP premiums). If these CARE/HIPP applicants do not

propose insurance costs below the relevant threshold listed below, they will be referred to PCIP and offered OA-PCIP coverage.

- CARE/HIPP applicants that are co-enrolled in ADAP – The cost threshold would be equivalent of the total cost of an OA-PCIP and ADAP client, which includes the monthly PCIP premium (based upon their age and location) plus the average monthly deductibles and co-pays (\$208.33) paid by ADAP.
- CARE/HIPP applicants that are not enrolled in ADAP – The cost threshold would be equivalent to the actual monthly PCIP premium (based upon their age and location).

If insurance premiums for current CARE/HIPP clients rise above the relevant cost threshold, the client would be responsible for paying the balance above the threshold. These cost thresholds will be evaluated, and revised as needed, annually.

Outreach and Education

OA will also provide comprehensive outreach and education activities for the expanded CARE/HIPP program in conjunction with the new OA-PCIP program. OA will develop and conduct outreach and education/training for LHJs, healthcare providers, community-based benefits counselors, and ADAP and CARE/HIPP enrollment workers. OA will collaborate with key stakeholders to identify additional outreach audiences, create marketing materials and disseminate information.

Staffing

OA anticipates utilizing existing budgeted positions during FY 2011-12 to implement CARE/HIPP expansion.

Revised Major Assumptions**1. ADAP PBM Contract: Transaction Fees and Negotiated Pharmacy Discount Split Savings****FROM November Estimate FY 2011-12:**

An RFP to implement a new PBM contract was to be effective July 1, 2010. The PBM RFP was withdrawn when it became clear that there was not sufficient time to allow for a transition to a possible new PBM provider. A new ADAP PBM RFP was released for services to begin in FY 2011-12. Services for FY 2010-11 were provided through a one-year contract that includes the provisions of the previous five year contract.

The RFP included two administrative changes to the PBM contract, effective July 1, 2011: 1) each non-approved transaction fee will be a \$3 maximum instead of the current \$6 maximum; and 2) non-approved transaction fees will be limited to five re-submittals instead of the current unlimited number of re-submittals.

CHANGE COMPARED TO November Estimate FY 2011-12:

The new ADAP PBM RFP was released, the notice of intent to award has been posted, and the contract will take effect on July 1, 2011. The selected PBM's cost proposal included approved transaction fees of \$4 instead of the current \$6 and non-approved transaction fees of \$2 instead of the estimated \$3 from the *November Estimate FY 2011-12*. The methodology used to calculate the transaction fee savings for *May Revision 2011-12* has not changed from that described in the *November Estimate FY 2011-12*. However, due to the additional PBM fee reductions and the updated FY 2011-12 expenditure estimate, OA estimated an additional \$4,225,355 in transaction fee savings. These changes result in an estimated total transaction fee savings of \$8,115,145 for FY 2011-12.

In addition, the PBM's cost proposal included a change to the negotiated pharmacy discount split savings. ADAP receives a percent of the savings the PBM negotiates with their contract pharmacies. ADAP has received a split savings on the negotiated discount since FY 2005-06 and this savings has been built into our linear regression. The PBM contracts for FYs 2009-10 and 2010-11 included a split savings of 50 percent/50 percent. The new PBM contract will include a split saving of 60 percent/40 percent with ADAP receiving 60 percent of the negotiated discount and the PBM receiving 40 percent.

The additional split savings for FY 2011-12 resulting from the proposed 60 percent/40 percent split were estimated by applying split savings and expenditure data from FY 2009-10 to the FY 2011-12 estimate of total expenditures; however, for brand drugs FY 2009-10 total split savings cannot be used to estimate the additional FY 2011-12 savings. Starting in April 2010, average wholesale price rollback decreased the total split savings for brand drugs, which would result in an overestimation of the new

savings for FY 2011-12. Instead, the additional split savings for brand and generic drugs were calculated separately, as outlined below.

To calculate the additional split savings for generic drugs, we computed the split savings for generic drugs in FY 2009-10 as a percentage of total expenditures. This percentage was applied to the FY 2011-12 expenditure estimate to represent total split savings. We then computed OA's portion of the split savings (60 percent) and subtracted from this what OA's portion would have been under the prior 50/50 agreement (50 percent). This difference of \$1.27 million represented the new additional savings for generic drugs for FY 2011-12.

The average wholesale price rollback started reducing split savings for brand drugs at the start of the last quarter of FY 2009-10. To compensate for this reduction, April, May, and June 2010 split savings and expenditures were annualized by multiplying both quarterly numbers by four. These annualized total split savings and expenditures were then applied using the same methodology as outlined for generic drugs, resulting in an additional \$65,626 in savings for brand drugs in FY 2011-12. This resulted in a total additional split fee savings of \$1,335,931 for FY 2011-12.

Taking into account the transaction fee savings and additional split fee savings, FY 2011-12 estimated savings for this Assumption totals \$9,451,076, which is \$5,561,285 more than the *November Estimate FY 2011-12* savings of \$3,889,791. However, due to Legislative Conference Committee removal of an additional \$4,000,000 from OA's General Fund budget authority (based on transaction fee savings), the net change from conference committee action to May Revision equals \$1,561,285.

2. One-Time Reimbursement: One-time federal funding through the Safety Net Care Pool

FROM *November Estimate FY 2011-12*:

On February 1, 2010, the Centers for Medicare and Medicaid Services approved the California Department of Health Care Services (DHCS) proposed amendment to the Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand DHCS's ability to claim additional state expenditures to utilize federal funding under the Safety Net Care Pool. DHCS used certified public expenditures from various programs, including ADAP, to claim federal funds. CDPH will receive \$76.277 million of these funds from DHCS as a reimbursement. The *November Estimate FY 2011-12* assumes the reimbursement will be spent in the current year.

CHANGE COMPARED TO *November Estimate FY 2011-12*:

In FY 2011-12, CDPH will receive \$74.1 million from DHCS as a one-time reimbursement due to additional federal funds available under the Safety Net Care Pool in FY 2011-12. As a result, \$74,064,000 was removed from OA's General Fund budget authority. The

May Revision FY 2011-12 assumes that the reimbursement will be spent in the budget year.

Discontinued Major Assumptions

1. Client Cost Sharing Policy—This proposal was rejected by the Legislature, and the department was directed to explore alternatives such as implementing PCIP and expanding CARE/HIPP as reflected in this *May Revision 2011-12* Estimate.

3. FUND CONDITION STATEMENT

(Updated for *May Revision*)

The FCS (see **Table 17**, next page) shows the status of the ADAP Special Fund (SF) for FYs 2009-10, 2010-11, and 2011-12 and all the factors that impact the fund including revenues, expenditures, revenue collection rate, interest earned, and major assumptions.

For FY 2010-11, revenue estimates are based on actual rebates collected for the period January through June 2010 (\$111,107,496) and actual expenditures for July through December 2010 (\$218,119,473). A 46 percent rebate collection rate was applied to the actual expenditures to arrive at estimated revenue of \$100,334,958. Actual rebates plus rebates estimated from actual expenditures resulted in projected revenue of \$211,442,454. These revenues were adjusted to reflect the impact of the renegotiated supplemental rebate and/or price freeze agreements yielding total revenue in the amount of \$223,383,222. It is estimated that there will be an additional amount of \$300,000 of revenue from interest.

For FY 2011-12, revenue estimates are based on updated projected expenditures for the period January through December 2011 (\$500,965,322). A 46 percent rebate collection rate was applied to the estimated expenditures and adjustments were made for three assumptions to arrive at the revenue projection of \$255,534,980. It is estimated that there will be an additional amount of \$300,000 of revenue from interest.

Based on the revised linear regression and impact of assumptions, the revised FY 2010-11 GF appropriation is \$54,406,000, a \$17,034,000 decrease from the *November Estimate FY 2011-12* for current year. The revised GF appropriation for FY 2011-12 is \$82,625,000, a decrease of \$21,040,000 from the Legislative Conference Committee decisions to the FY 2011-12 Governor's Budget and an increase of \$28,219,000 from the revised FY 2010-11 appropriation.

MAY REVISION FUND CONDITION STATEMENT

Table 17: FUND CONDITION STATEMENT (in thousands)				
	Special Fund 3080 AIDS Drug Assistance Program Rebate Fund	FY 2009-10 Actuals	FY 2010-11 Estimate	FY 2011-12 Estimate
1	BEGINNING BALANCE	91,183	11,309	7,948
2	Prior Year Adjustment	-85	0	0
3	Adjusted Beginning Balance	91,098	11,309	7,948
4	REVENUES, TRANSFERS AND OTHER ADJUSTMENTS			
5	Revenues			
6	150300 Income From Surplus Money Investments	315	300	300
7	161400 Miscellaneous Revenue	171,085	223,383	255,535
8	Total Revenues, Transfers, and Other Adjustments	171,400	223,683	255,835
9	Total Resources	262,498	234,992	263,783
10	EXPENDITURES AND EXPENDITURE ADJUSTMENTS			
11	Expenditures			
12	8880 FISCAL		1	1
13	0840 State Controllers Office	23	56	33
14	4260 Department of Health Care Service (State Ops)	15		
15	4265 Department of Public Health			
16	State Operations	905	896	997
17	Local Assistance	250,246	226,091	253,827
18				
19				
20	Total Expenditures and Expenditure Adjustments	251,189	227,044	254,858
21	FUND BALANCE	11,309	7,948	8,925

Row 6: Actuals for FY 2009-10, Estimated for FYs 2010-11 and 2011-12

315,308 300,000 300,000

Miscellaneous Revenue

Actual Rebates Collected for Jan - March 2010 expenditures	55,919,217	
Actual Rebates Collected for April - June 2010 expenditures	55,188,279	
Subtotal: Actual Rebates Collected	111,107,496	
Actual Expenditures for July - December 2010	218,119,473	
Estimated Expenditures for Jan - June 2011		240,978,041
Estimated Expenditures for July - Dec 2011		259,987,281
Estimated Calendar Year Expenditures		500,965,322
Estimated Revenue at 46% Rebate Collection Rate for FY 2010-11 on: \$218,119,473	100,334,958	
Total Projected Revenue (\$111,107,496 + \$100,334,958) FY 2010-11	211,442,454	
Estimated Revenue at 46% Rebate Collection Rate for FY 2011-12 on \$500,965,322		230,444,048
Revenue Impact: Renegotiated Sup. Rebate/Price Freeze Agreements for Jan-Jun 2010 expenditures	352,081	
Revenue Impact: Renegotiated Sup. Rebate/Price Freeze Agreements (for FY 2010-11: Jul - Dec 2010 expenditures, for FY 2011-12: Jan - Dec 2011 expenditures)	11,588,688	26,616,288
Revenue Impact: Pre-Existing Condition Insurance Plan (PCIP) (New Major Assump. #1)		-1,833,865
Revenue Impact: Expansion of CARE/HIPP (Net) (New Major Assump. #2)		308,510

Row 7: Projection of Total Revenue after adjustments

223,383,222 255,534,980

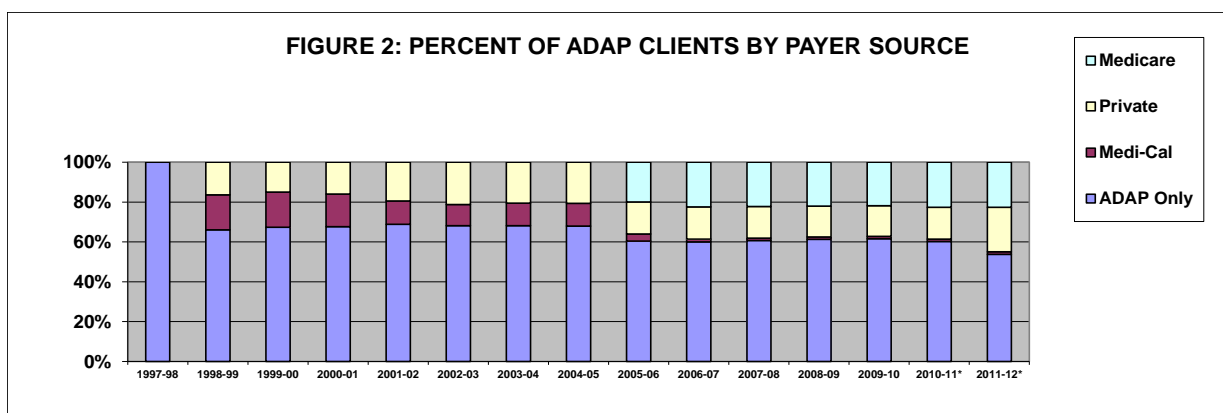
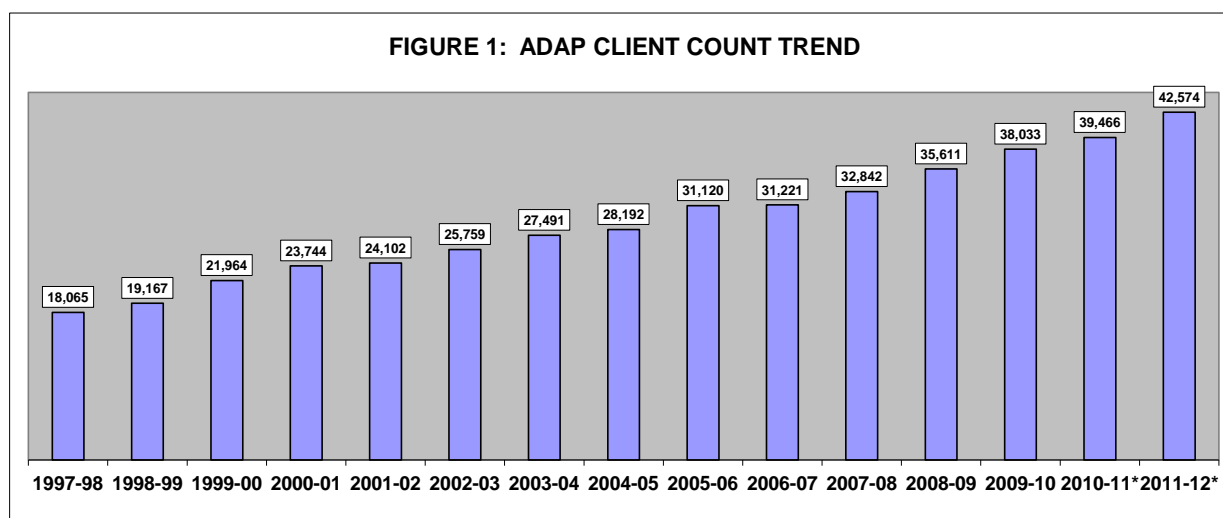
Expenditure Projections: FYs 2010-11 and 2011-12, Linear Regression	462,891,105	538,139,086
Administrative Reduction to PBM Contract (GF Reduction)	-500,000	0
Subtotal: Local Assistance Expenditure Estimate	462,391,105	538,139,086
Expenditure Impact: PBM Contract: Transaction Fee Savings (Revised Major Assump. #1)	0	-8,115,145
Expenditure Impact: PBM Contract: Split Fee Savings (Revised Major Assump. #1)		-1,335,931
Expenditure Impact: Leg. Affecting Medicare Pt. D True-Out-Of-Pocket Costs (HCR)	-3,293,590	-6,812,485
Expenditure Impact: PBM Contract: Change in Pharmacy Reimbursement Rate		-1,900,964
Subtotal: Local Assistance Expenditure Estimate Prior to PCIP and C/H Adjustments		519,974,561
Expenditure Impact: Pre-Existing Condition Insurance Plan (PCIP) (New Major Assump. #1)		-9,944,971
Expenditure Impact: Expansion of CARE/HIPP (New Major Assump. #2)		-6,409,898
Subtotal: Expenditure Projection after Adjustments	459,097,515	503,619,692

Subtotal: Expenditure Projection after Adjustments	459,097,515	503,619,692
Less: Federal Fund Appropriation (Earmark) (Effective April 1 of Grant Year)	-97,631,979	-97,631,979
Less: One-Time Federal Fund 2009 Carryover (Section 28)	-1,741,249	
Less: One-Time increase in FF RW Part B Supplemental Award	-2,659,865	
Less: One-Time FF increase in RW Part B ADAP Shortfall Relief Award	-2,423,137	
Less: Anticipated One-Time FF increase in RW Part B Supplemental Award		-3,000,000
Subtotal Federal Fund	-104,456,230	-100,631,979
Less: Reimbursement Funding through the Safety Net Care Pool (Revised Major Assump. #2)	-76,277,000	-74,064,000
Less: General Fund Appropriation - per 10/11 Budget Act	-125,608,000	-125,608,000
General Fund Savings due to increased Transaction Fee Savings (Revised Major Assump. #1)		4,000,000
General Fund Savings due to Anticipated Federal Supplemental Funding		3,000,000
General Fund Savings due to Reimbursement (Revised Major Assump. #2)	76,277,000	74,064,000
General Fund Need to Avoid a Negative Fund Balance	0	-29,156,000
Additional General Fund Need to Achieve a Prudent Reserve (at 3.50%)	-5,075,000	-8,925,000
Subtotal General Fund Revised Appropriation	-54,406,000	-82,625,000
Special Fund 3080 Need to meet Expenditure Projection	223,958,285	246,298,713
Local Assistance Local Health Jurisdiction (LHJ)	1,000,000	1,000,000
Local Assistance Medicare Part D premiums	1,000,000	1,000,000
Local Assistance OA-PCIP Premiums		2,375,949
Local Assistance CARE/HIPP Premiums		3,019,433
Tropism Assay	132,623	132,623
Row 17: Total Special Fund 3080 Need	226,090,908	253,826,718

4. HISTORICAL PROGRAM DATA AND TRENDS

(*Data for FYs 2010-11 and 2011-12 are estimated, all other data are actuals)
(Updated for May Revision)

For all figures and tables in Section 4, the data prior to FY 2010-11 is the observed historical data, and thus includes jail transactions. To develop client and prescription estimates for FYs 2010-11 and 2011-12, we used a model similar to the 36-month regression model for expenditure estimates removing the jail expenditures, where the 36 monthly data points were the number of clients and prescriptions with jail clients and prescriptions removed.

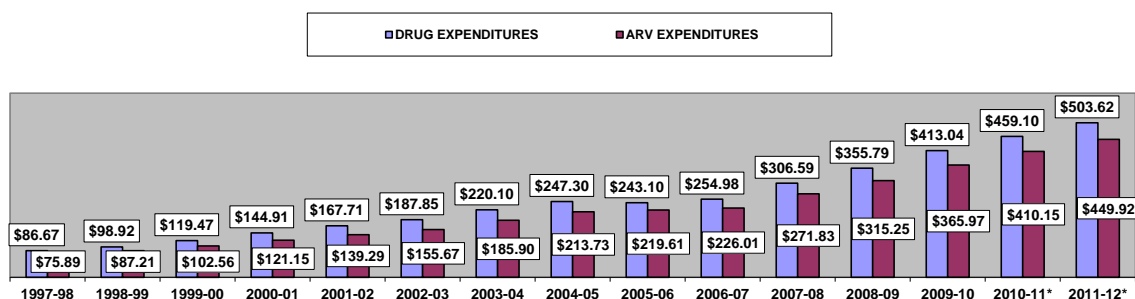


Note: The actual percentage of ADAP clients (minus jail clients) by payer source/coverage group in FY 2009-10 was applied to the estimated client counts in FYs 2010-11 and 2011-12 to estimate the percentage of clients by payer source.

TABLE 18: ESTIMATED ADAP CLIENTS BY COVERAGE GROUP				
	FY 2010-11*		FY 2011-12*	
COVERAGE GROUP	CLIENTS	PERCENT	CLIENTS	PERCENT
ADAP	23,755	60.19%	22,910	53.81%
Medi-Cal	486	1.23%	524	1.23%
Private Insurance	6,298	15.96%	9,509	22.33%
Medicare	8,928	22.62%	9,631	22.62%
TOTAL	39,466	100.00%	42,574	100.00%

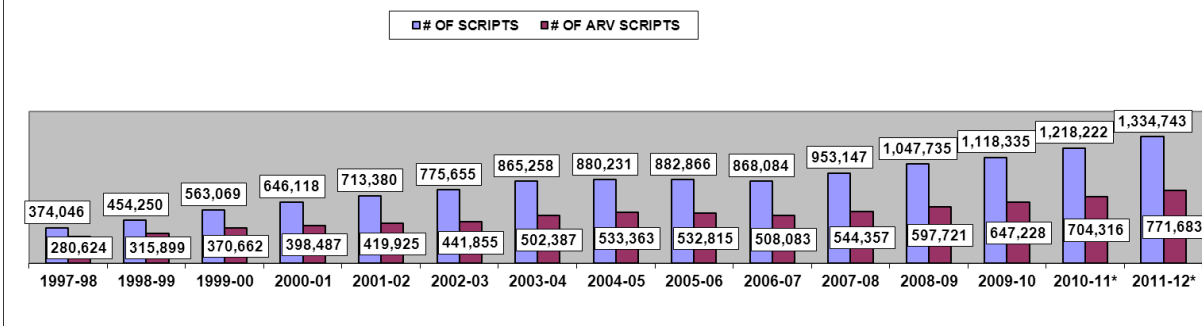
Note: The actual percentage of ADAP clients (minus jail clients) by payer source/coverage group in FY 2009-10 was applied to the estimated client counts in FYs 2010-11 and 2011-12 to estimate the percentage of clients by payer source.

FIGURE 3: ADAP DRUG EXPENDITURE TREND
(in millions)

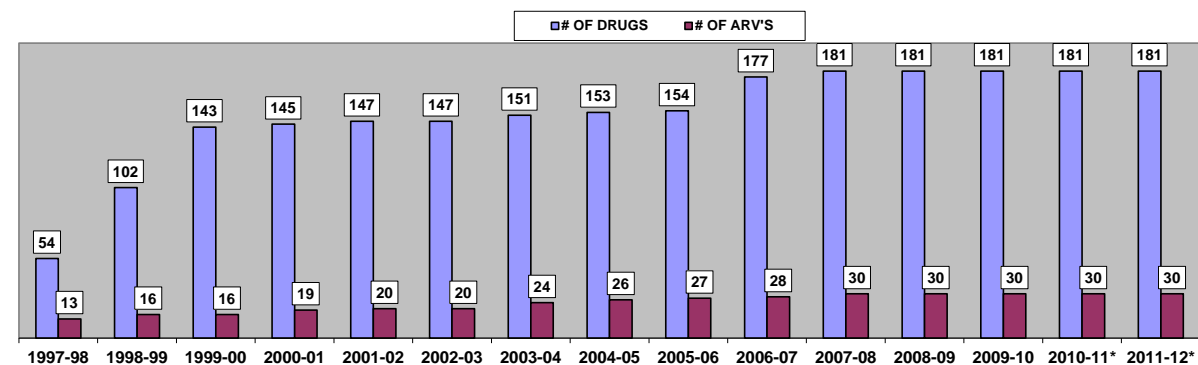


Note: Drug expenditures do not include: Tropism Assay laboratory test required to demonstrate clinical indication for one of the antiretroviral (ARV) agents covered by ADAP, annual administrative support for LHJs, Medicare Part D premium payments, CARE/HIPP and OA-PCIP premium payments; for these costs see page 35.

Note: For ARV expenditures, we used the percentage of ARV expenditures without jail prescriptions in FY 2009-10 and applied it to the estimated drug expenditures in FYs 2010-11 and 2011-12 to estimate the percentage of ARV expenditures.

FIGURE 4: ADAP # OF PRESCRIPTIONS TREND

Note: For the number of ARV prescriptions, we used the percentage of ARV prescriptions without jail prescriptions in FY 2009-10 and applied it to the estimated drug prescriptions in FYs 2010-11 and 2011-12 to estimate the number of ARV prescriptions.

FIGURE 5: ADAP # OF FORMULARY DRUGS TREND

APPENDIX A: EXPENDITURE AND REVENUE ESTIMATE METHODS(Updated for *May Revision*)**Updated Expenditure Estimate for FY 2010-11**

TABLE 19: LINEAR REGRESSION MODEL FOR MAY REVISION COMPARED TO NOVEMBER ESTIMATE for FY 2010-11 (ACTUAL DATA APRIL 2008 THROUGH FEBRUARY 2011, ESTIMATED FOR MARCH 2011)			
May Revision	November Estimate	Change from Previous Estimate (\$)	Change from Previous Estimate (%)
\$462,891,105	\$480,321,780	(\$17,430,675)	-3.63%

Updated Expenditure Estimate for FY 2011-12

TABLE 20: LINEAR REGRESSION MODEL FOR MAY REVISION COMPARED TO NOVEMBER ESTIMATE for FY 2011-12 (ACTUAL DATA APRIL 2008 THROUGH FEBRUARY 2011, ESTIMATED FOR MARCH 2011)			
May Revision	November Estimate	Change from Previous Estimate (\$)	Change from Previous Estimate (%)
\$538,139,086	\$545,902,686	(\$7,763,600)	-1.42%

Linear Regression Model – Expenditure Estimates

The linear regression methodology is the same as the method used to estimate expenditures for FYs 2010-11 and 2011-12 in the *November Estimate FY 2011-12* with two caveats: 1) We used the updated range of actual expenditures, from April 2008 through February 2011, as opposed to the August 2007 to July 2010 range used in the *November Estimate FY 2011-12*; and 2) we estimated March 2011 expenditures by a) taking the invoiced expenditures for the first seven days of March; b) calculating the daily expenditure rate; and c) applying that expenditure rate to the entire month. Using a more recent set of actual expenditure data to predict future expenditures allowed us to “fine tune” our previous estimates. Actual expenditures were lower than the estimated values previously predicted by the regression model used for the *November Estimate FY 2011-12*, which resulted in the lower expenditure estimates for both FYs 2010-11 and FY 2011-12 noted in **Tables 19 and 20**.

Figure 6 shows ADAP historic expenditures by month and March 2011 projected expenditures. The (thick straight red) regression line represents the best fitting straight line for estimating the expenditures:

- During normal growth periods, a linear regression model should accurately predict expenditures (the red regression line goes straight through the data points).
 - During low growth periods, a linear regression model would overestimate expenditures (the red regression line goes over the data points).
 - During high growth periods, a linear regression model using the point estimate would underestimate expenditures (the red regression line goes under the data points).
- Thus, given the recent relatively high growth expenditure period beginning in FY 2007-08, and the desire not to underestimate the need for ADAP to utilize the ADAP SF to address increasing expenditures, we continue to use the upper bound of the 95 percent confidence interval around the point estimate for our regression estimates. This is the same strategy used during the previous estimate development.

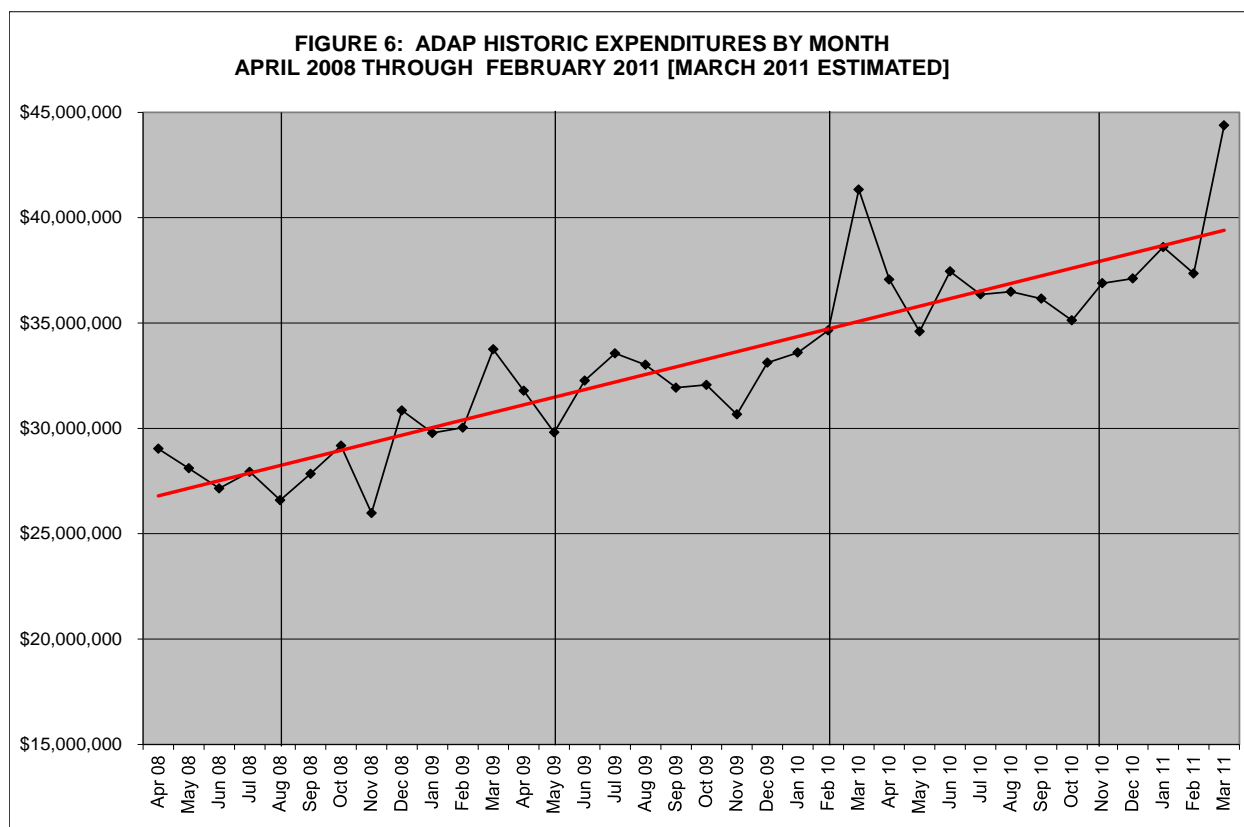


Table 21 displays historic drug expenditures by FY, annual change, and percent change.

TABLE 21: ADAP HISTORIC AND PROJECTED DRUG EXPENDITURES			
(*Data for FY 2010-11 and FY 2011-12 are projected, all other data are actuals)			
Fiscal Year	Expenditures	Annual Change in Expenditures	Pct Annual Change
1997-98	\$86,674,336	N/A	N/A
1998-99	\$98,924,742	\$12,250,405	14.13%
1999-00	\$119,465,151	\$20,540,409	20.76%
2000-01	\$144,913,504	\$25,448,353	21.30%
2001-02	\$167,709,426	\$22,795,922	15.73%
2002-03	\$187,854,138	\$20,144,712	12.01%
2003-04	\$220,101,760	\$32,247,622	17.17%
2004-05	\$247,299,716	\$27,197,956	12.36%
2005-06	\$243,096,942	-\$4,202,774	-1.70%
2006-07	\$254,977,392	\$11,880,450	4.89%
2007-08	\$306,590,832	\$51,613,440	20.24%
2008-09	\$355,786,400	\$49,195,569	16.05%
2009-10	\$413,035,251	\$57,248,851	16.09%
2010-11*	\$459,097,515	\$46,062,264	11.15%
2011-12*	\$503,619,692	\$44,522,177	9.70%
Total Average	FY 97-98 to 11-12	\$29,781,811	13.56%

Note: Drug costs include administrative costs at the pharmacy and PBM level.

Drug costs do not include: Tropism Assay laboratory test required to demonstrate clinical indication for one of the antiretroviral (ARV) agents covered by ADAP, annual administrative support for LHJs, Medicare Part D premium payments, CARE/HIPP and OA-PCIP premium payments; for these costs see page 35.

Notes: In FY 2005-06, ADAP expenditures decreased for the first time due to the enrollment of ADAP clients in Medicare Part D starting in January 2006. This also resulted in a lower than average increase in expenditures in FY 2006-07. The annual percentage increase in expenditures has decreased over the last two years because of the elimination of jail clients and the changes to TrOOP in FY 2010-11. The new estimated PCIP and CARE/HIPP savings explain the additional anticipated decrease in FY 2011-12.

Program Expenditure Estimate for FY 2011-12 (Updated for May Revision)

In addition to the drug expenditures noted in **Table 22**, total estimated program costs include:

1. Administrative support for LHJs: \$1 million.
2. Medicare Part D premium payments: \$1 million.
3. OA-PCIP premiums: \$2,375,949.
4. CARE/HIPP premiums: \$3,019,433.
5. Tropism Assay: \$132,623

TABLE 22: HISTORIC ADAP REBATE REVENUE COLLECTION PERCENTS BY QUARTER			
FY-QTR	\$ Drugs Purchased	Received in Rebate \$	Received / Purchased
2002-03-Q1	\$46,263,616	\$10,136,693	21.91%
2002-03-Q2	\$46,714,748	\$10,257,857	21.96%
2002-03-Q3	\$47,028,955	\$10,146,224	21.57%
2002-03-Q4	\$47,846,818	\$10,846,426	22.67%
2003-04-Q1	\$51,607,688	\$12,275,494	23.79%
2003-04-Q2	\$51,732,389	\$15,045,513	29.08%
2003-04-Q3	\$56,857,403	\$17,801,378	31.31%
2003-04-Q4	\$59,904,280	\$19,249,713	32.13%
2004-05-Q1	\$61,533,761	\$19,334,264	31.42%
2004-05-Q2	\$60,894,584	\$18,691,012	30.69%
2004-05-Q3	\$61,680,181	\$19,176,357	31.09%
2004-05-Q4	\$63,191,190	\$15,847,186	25.08%
2005-06-Q1	\$63,433,758	\$21,866,164	34.47%
2005-06-Q2	\$62,536,173	\$20,612,704	32.96%
2005-06-Q3	\$58,562,814	\$26,768,577	45.71%
2005-06-Q4	\$58,564,197	\$25,095,840	42.85%
2006-07-Q1	\$60,334,084	\$24,791,394	41.09%
2006-07-Q2	\$58,609,374	\$24,489,071	41.78%
2006-07-Q3	\$67,474,884	\$32,724,197	48.50%
2006-07-Q4	\$68,559,050	\$31,734,710	46.29%
2007-08-Q1	\$68,797,779	\$33,524,051	48.73%
2007-08-Q2	\$71,581,717	\$35,262,749	49.26%
2007-08-Q3	\$81,926,045	\$44,200,318	53.95%
2007-08-Q4	\$84,285,291	\$39,834,969	47.26%
2008-09-Q1	\$82,366,671	\$36,272,892	44.04%
2008-09-Q2	\$85,997,429	\$38,043,925	44.24%
2008-09-Q3	\$93,564,283	\$46,300,283	49.48%
2008-09-Q4	\$93,858,017	\$40,827,251	43.50%
2009-10-Q1	\$98,508,463	\$44,718,090	45.40%
2009-10-Q2	\$95,842,924	\$44,131,629	46.05%
2009-10-Q3	\$109,578,075	\$55,919,217	51.03%
2009-10-Q4	\$109,105,789	\$55,188,279	50.58%

ADAP Rebate Revenue Estimate Method

To forecast future revenue, the rebate revenue estimate method applies the expected revenue collection rate (46 percent) to estimated or actual expenditures (whichever is more current). Estimated revenue for a given FY is based on drug expenditures during the last two quarters of the previous FY and the first two quarters of the current fiscal year. This six-month delay is necessary to take into account the time required for billing the drug manufacturers and receipt of the rebate. Revenue projections are adjusted to reflect assumptions and other adjustments that can increase or decrease revenues.

Revenue estimates for the *May Revision FY 2011-12* for current year were developed using actual rebates collected for the period January through June 2010 and actual expenditures for July through December 2010 (see **Table 23**, next page). A 46 percent rebate collection rate was applied to the actual expenditures to arrive at estimated revenue of \$100,334,958. The resulting estimated revenue (\$211,442,454) was then adjusted due to the fiscal impact of the new, revised, and continuing assumptions (Section 2, page 5).

Revenue for the *May Revision FY 2011-12* for budget year was based on updated estimated expenditures for the period January through December 2011, applying the 46 percent rebate collection rate to arrive at the revenue projection of \$230,444,048 and adjusted for the new, revised and continuing assumptions (Section 2, page 5).

It should be noted that the revenue estimate method uses average expenditures for each six-month period and does not directly take into account the seasonal behavior of expenditures that historical data show. As noted in previous Estimates, historical data show that drug expenditures are lower in the first half of the FY (July through December) compared to the second half.

TABLE 23: COMPARISON OF REVENUE* BETWEEN MAY REVISION AND NOVEMBER ESTIMATE FOR FY 2010-11 AND FY 2011-12						
UPDATED ESTIMATE FOR FY 2010-11						
Expenditure Period	Available Data	May Revision	Available Data	November Estimate	Change (\$)	Change (%)
Jan - Mar 2010	Actual Rebates	\$55,919,217	Actual Expenditures @ 46%	\$53,030,370	\$2,888,847	5.45%
Apr - Jun 2010	Actual Rebates	\$55,188,279	Actual Expenditures @ 46%	\$50,188,663	\$4,999,616	9.96%
Jul- Dec 2010	Actual Expenditures @ 46%	\$100,334,958	Estimated Expenditures @ 46%	\$109,572,494	-\$9,237,536	-8.43%
Subtotal Revenue		\$211,442,454		\$212,791,527	-\$1,349,073	-0.63%
FY 2010-11	Renegotiated Supplemental Rebate/Price Freeze Agreements for Jan - Jun 2010	\$352,081	Renegotiated Supplemental Rebate/Price Freeze Agreements for Jan - Jun 2010	\$352,081	\$0	0.00%
FY 2010-11	Renegotiated Supplemental Rebate/Price Freeze Agreements for FY 2010-11: Jul-Dec 2010	\$11,588,688	Renegotiated Supplemental Rebate/Price Freeze Agreements for FY 2010-11: Jul-Dec 2010	\$12,655,623	-\$1,066,935	-8.43%
Subtotal Revenue		\$223,383,222		\$225,799,231	-\$2,416,009	-1.07%
Interest		\$300,000		\$300,000	\$0	0.00%
Total Revenue (see Table 17, Fund Condition Statement)		\$223,683,222		\$226,099,231	-\$2,416,009	-1.07%
UPDATED ESTIMATE FOR FY 2011-12						
Expenditure Period	Available Data	May Revision	Available Data (Expenditure Period)	Governor's Budget	Change (\$)	Change (%)
Jan - Jun 2011	Estimated Expenditures @ 46%	\$110,849,899	Estimated Expenditures @46%	\$109,572,494	\$1,277,405	1.17%
Jul - Dec 2011	Estimated Expenditures @ 46%	\$119,594,149	Estimated Expenditures @46%	\$122,629,384	-\$3,035,235	-2.48%
Subtotal Revenue		\$230,444,048		\$232,201,878	-\$1,757,830	-0.76%
FY 2011-12	Renegotiated Supplemental Rebate/Price Freeze Agreements for FY 2011-12: Jan - Dec 2011	\$26,616,288	Renegotiated Supplemental Rebate/Price Freeze Agreements for FY 2011-12: Jan - Dec 2011	\$26,819,317	-\$203,029	-0.76%
FY 2011-12	Pre-Existing Condition Insurance Plan (PCIP) (New Major Assump #1)	-\$1,833,865		\$0	-\$1,833,865	0.00%
FY 2011-12	Expansion of CARE/HIPP (New Major Assumption #2)	\$308,510		\$0	\$308,510	0.00%
Subtotal Revenue		\$255,534,980		\$259,021,195	-\$3,486,215	-1.35%
Interest		\$300,000		\$300,000	\$0	0.00%
Total Revenue (see Table 17, Fund Condition Statement)		\$255,834,980		\$259,321,195	-\$3,486,215	-1.34%

*Note: When actual rebate data are not available, revenue projection methodology bases revenue first on estimated and then actual expenditures. This method does not take into account the seasonal fluctuations between the first half of the FY (when expenditures are lowest) and the second half (when expenditures are highest).

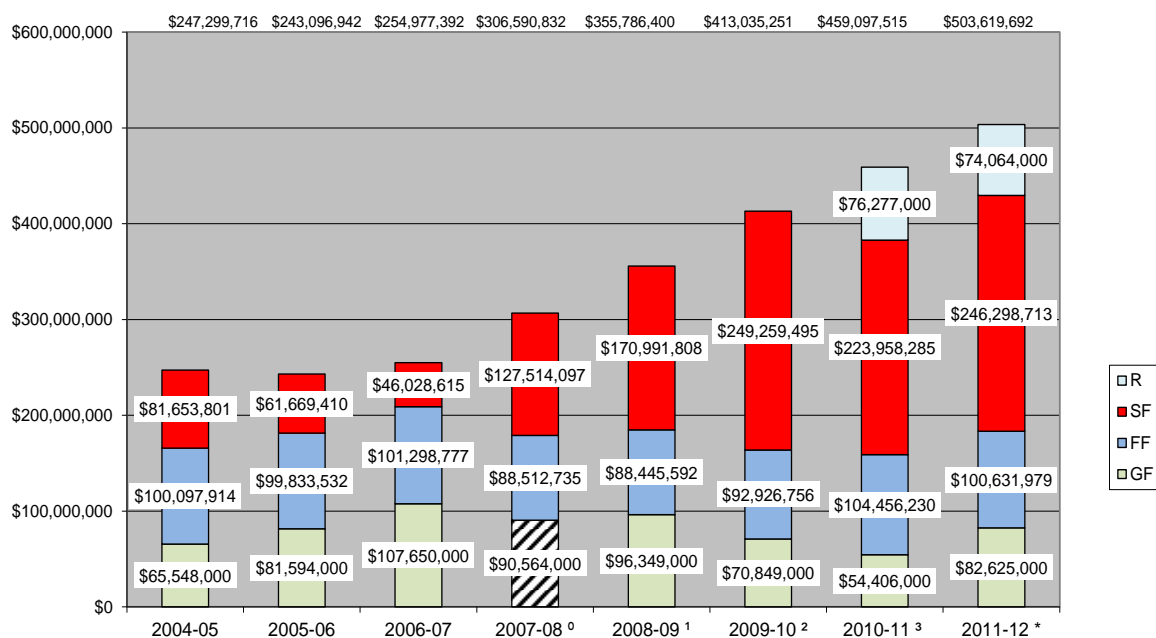
APPENDIX B: FUND SOURCES

(Updated for *May Revision*)

Payments of ADAP expenditures are made from four fund sources:

1. State General Fund appropriations.
2. Federal funding from the Health Resources and Services Administration (HRSA) through the Ryan White Program. In addition, for FY 2010-11, OA received three one-time fund awards: Ryan White Part B Supplemental Award of \$2,659,865, Ryan White Part B ADAP Shortfall Relief Award of \$2,423,137, and a carryover from the 2009 Ryan White Part B HIV Care Grant of \$1,741,249.
3. Reimbursements from DHCS are one-time funding sources for FYs 2010-11 and 2011-12, as a result of additional federal resources available through the Safety Net Care Pool.
4. ADAP SF consists of both mandatory and voluntary rebates from manufacturers with products on the ADAP formulary and interest payments from ADAP SF.

FIGURE 7: ADAP HISTORIC DRUG EXPENDITURES BY FUNDING SOURCE
(Data for FYs 2010-11 and 2011-12 are estimated, all other data actual)



⁰ FY 2007-08: One time \$7.285 M GF return; one time \$9.8 M GF redirection to other OA programs for a total of \$17.085 M backfilled with SF; permanent reduction of \$10.530 M FF, backfilled with SF.

¹ FY 2008-09: Base \$107.650 M GF allocation reduced by a permanent reduction of \$7 M and \$4 M redirection to other OA programs.

² FY 2009-10: Permanent reduction of \$25.5 M GF, backfilled with \$25 M SF (net -\$500 K) to avoid a reduction in program services; including permanent reduction and redirection of previous FYs.

³ FY 2010-11: Reflects \$11.5 M FF increase (\$6.8 M FF in one time increase and \$4.7 M FF permanent increase), \$76.2M one-time reimbursement, \$16.4 GF decrease, and \$25.3M SF decrease from FY 2009-10 Budget Act.

^{*} FY 2011-12: Reflects \$3.8M FF decrease, \$28.2M GF increase, \$22.3M SF increase and \$74.1M one-time Reimbursement.

General Fund

ADAP's GF allocation is used for the purchase of prescription drugs for eligible clients. It is the only source of funding used by ADAP to meet the Medi-Cal share of cost for eligible clients. This fund source also pays a portion of the transaction fees invoiced by ADAP's PBM contractor to pay for the administrative costs associated with managing prescription transactions that are ultimately identified as not eligible for ADAP payment.

For the *May Revision FY 2011-12*, the revised FY 2010-11 GF appropriation is \$54,406,000, a \$17,034,000 decrease from the *November Estimate FY 2011-12* for the current year. The GF appropriation for FY 2011-12 is \$82,625,000, a decrease of \$21,040,000 from the Legislative Conference Committee decisions to the FY 2011-12 Governor's Budget and an increase of \$28,219,000 from the revised FY 2010-11 appropriation.

Federal Fund

Federal funding from the annual HRSA grant award through Ryan White includes both "Base" funding and "ADAP Earmark" funding. The Base award from the grant provides funds for care and support programs within OA. The Part B Earmark award must be used for ADAP-related services only. The Ryan White award is predicated upon the State of California meeting Maintenance of Effort (MOE) and match requirements. Non-compliance with these requirements will result in withholding a portion (match) or the entire (MOE) Part B federal grant award to California.

For FY 2010-11, ADAP received an increase in Earmark Federal funding of \$4,705,223 for a total of \$97,631,979 as well as three one-time fund awards: Ryan White Part B Supplemental Award of \$2,659,865, ADAP Shortfall Relief Award of \$2,423,137, and a carryover from the 2009 Ryan White Part B HIV Care Grant of \$1,741,249. The total increase in federal funds for FY 2010-11 is \$11,529,474, which includes a presumably permanent increase as well as the two one-time supplements and one-time carryover.

For FY 2011-12, ADAP has applied for \$97,631,979 in Earmark Federal funding, \$2,659,865 in Ryan White Part B Supplemental funding, and \$2,423,137 in ADAP Shortfall Relief funding. Due to the current Federal Continuing Resolution, the amount awarded on March 24, 2011 for ADAP Earmark in the Ryan White Grant is approximately 48 percent of the total that OA applied for. The supplemental grants will be awarded after there is a Federal budget.

Similar to other federal grants, the Ryan White Grant is being allocated in partial payments. We have no indications that full year funding is in jeopardy and thus, we are continuing to develop the *May Revision 2011-12* estimate as if we will receive our entire year's resources once a Federal budget is in place.

Match

HRSA requires grantees to have HIV-related non-HRSA expenditures of at least one-half of the HRSA grant award. Since California's 2010 HRSA grant award is \$134,604,892, the match requirement for FY 2010-11 funding is \$66,834,681.

MOE

HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior FY. California's MOE target, based on FY 2009-10 expenditures at the time of the Year 2011 HRSA grant application, is \$502,476,676. Expenditures included in California's MOE calculations are not limited to OA programs and include HIV-related expenditures for all state agencies able to report GF expenditures specific to HIV-related activities such as care, treatment, prevention, and surveillance. Expenditures from the SF may be used towards the MOE requirement.

Reimbursement

On February 1, 2010, the Centers for Medicare and Medicaid Services approved the DHCS proposed amendment to the Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand DHCS's ability to claim additional state expenditures to utilize federal funding under the Safety Net Care Pool. DHCS used certified public expenditures from various programs, including ADAP, to claim federal funds. CDPH will receive \$76,277,000 of these funds from DHCS as a reimbursement for FY 2010-11 and \$74,064,000 for FY 2011-12.

ADAP SF (3080)

The use of this fund is established under both state law and federal funding guidance. The ADAP SF was legislatively established in 2004 to support the provision of ADAP services. Section 120956 of the California Health and Safety (H&S) Code, which established the ADAP SF, states in part:

"... (b) All rebates collected from drug manufacturers on drugs purchased through the ADAP implemented pursuant to this chapter and, notwithstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP ..."

ADAP receives both mandatory and voluntary supplemental rebates for drugs dispensed to ADAP clients, the former rebate required by state (H&S Code Section 120956) and federal (Medicaid) law and the latter negotiated with individual drug manufacturers. Though these rebates constitute a significant part of the annual ADAP budget, the exact amount of rebate to be collected on an annual basis varies due to a number of factors, including quarterly changes in the federal calculation for the

mandatory rebate due on the part of the manufacturer and the “voluntary” nature of the supplemental rebates.

Supplemental rebates (rebates beyond those required by the federal Medicaid rebate law) are negotiated on an ongoing basis by the national AIDS Crisis Task Force (ACTF). The ACTF is a rebate negotiating coalition of some of the largest ADAPs in the country (including California), working on behalf of all state ADAPs. The ACTF enters into voluntary, confidential supplemental rebate agreements with drug manufacturers.

Though these agreements are entered into in good faith by both parties, there is no guaranteed continuation of the voluntary supplemental rebate. The agreements are generally entered into for an average term of one to two years but the drug manufacturer or the program can cancel the voluntary supplemental rebate agreement at any time with a 30-day written notice. Additionally, the rebate agreements are highly confidential and any unauthorized disclosure could invalidate the agreements, resulting in serious national implications for all state ADAPs.

Supplemental rebate agreements are in place for all ARVs on the ADAP formulary. This is significant, as ARV drugs’ represent approximately 90 percent of all ADAP drug expenditures. Supplemental rebate agreement terms are generally based on either:

- 1) an additional rebate percentage; and/or
- 2) a price freeze.

Additional Rebate Percentage

The mandatory 340B rebate is a percentage of the average manufacturers price (AMP), plus any penalties for price increases that exceed the rate for the Consumer Price Index (CPI). Since the AMP is confidential and not publicized, the resulting rebate amount is also unknown to ADAP. ACTF negotiations usually result in an additional voluntary, supplemental percentage of the AMP. For example, the current mandatory 340B rebate for brand drugs is 23 percent of AMP. If the ACTF has negotiated a supplemental rebate of 2 percent of AMP, then ADAP receives a total rebate of 25 percent of AMP.

“Price Freeze” Rebates

The “price freeze” option is another type of voluntary rebate offered by the manufacturer to compensate for commercial price increases. Currently, of the 31 available ARV medications on the ADAP formulary, ten (32 percent) are subject to a price freeze rebate. These ten drugs represented 52 percent of ADAP drug expenditures in FY 2009-10. If the manufacturers impose a price increase that exceeds the CPI (inflation rate) while the price freeze is in effect, the program reimburses retail pharmacies at the higher rates. Though this initially results in higher expenditures for the program, these price freeze agreements eventually offset the cost by increased rebates received and deposited in the SF.

ADAP Rebate Invoicing

ADAP invoices the manufacturers for drug rebates on a quarterly basis, consistent with both federal drug rebate law and drug industry standards. All ADAPs are required to invoice drug manufacturers within 90 days of the end of a given calendar year quarter (e.g., January through March, April through June, etc.) in compliance with federal requirements. ADAP mails drug rebate invoices approximately 60 days after the end of the quarter. For example, the January through March quarter invoice is sent out June 1. The time between the end of the billing quarter and the mailing of the invoice is necessary to generate and confirm the accuracy of the rebate invoices.

Timeframe for Receipt of Rebates

Federal HRSA guidance on ADAP rebate indicates that drug manufacturers are to pay rebate invoices from ADAP within 90 days of receipt. Federal Medicaid rebate law requires that drug manufacturers pay drug rebates within 30 days of receipt of a rebate invoice. Historically, the majority of drug manufacturers have paid rebates more closely to the Medicaid payment timeframe, usually within 30 to 60 days. However, receipt of rebate payments due for the first two quarters of calendar year 2010 indicate the manufacturers are now more closely following the HRSA timeframe of 90 days when processing ADAP rebate invoices.

Due to the above invoicing requirements and rebate payment timeframes, ADAP generally receives drug rebates six to nine months after program expenditures. Consequently, rebate due on expenditures in the second half of a given FY may not be received until the subsequent FY.

Funding from SF (3080) for LHJs, Medicare Part D, and Tropism Assay

Additional SF budget authority is requested as follows:

- \$1 million to LHJs to help offset the costs of ADAP enrollment and eligibility screening for clients at enrollment sites located throughout the state. Allocation is based on the number of ADAP clients enrolled during the prior calendar year. Funds may only be used for cost associated with the administration of ADAP.
- \$1 million for the Medicare Part D Premium Payment Program. This program assists eligible clients in paying their Part D monthly premiums allowing them to receive the Part D benefit.
- \$2,375,949 to cover premium payments for OA-PCIP.
- \$3,019,433 to cover premium payments for CARE/HIPP expansion.
- \$132,623 to cover the costs of Tropism Assay, a laboratory-based blood test used to determine whether a client will benefit from the use of Maraviroc, one of the ARV medications on the ADAP formulary.

APPENDIX C: POLICY ISSUES WITH POTENTIAL FUTURE FISCAL IMPACT

ADAP continues to monitor policy issues that have the potential to impact the fiscal condition of ADAP. These issues can occur within the state and federal arenas as well as the private sector. Because the future fiscal impact may be difficult to estimate, ADAP assesses the status of these issues on an ongoing basis. These issues are summarized below:

Potential for Fiscal Impact in FY 2011-12

1. One-Time Increase in Federal Funds: 2011 Ryan White (RW) ADAP Supplemental Application
CDPH applied for an ADAP 2011 RW Supplemental grant (\$2,423,137 requested). This supplemental grant is for states with a waiting list in 2010 and those that anticipate instituting a waiting list or other cost-saving strategies in 2011. The anticipated announcement and award date for these funds will be determined after there is a Federal budget in place.
2. One-Time Increase in Federal Funds: 2011 RW Part B Supplemental Application
CDPH applied for a 2011 RW Part B supplemental grant which CDPH will use for ADAP (\$2,659,865 requested). This supplemental application addresses how states propose to eliminate, reduce or avoid ADAP program restrictions including: waiting lists, capped enrollment, reduction to ADAP formulary, and reduction in the percentage of FPL requirements or other program restrictions on ADAP within the jurisdiction. The anticipated announcement and award date for these funds will be determined after there is Federal budget in place.
3. California Bridge to Reform, Section 1115 Demonstrations Waiver
Non-disabled ADAP clients with family incomes up to 200 percent of FPL who were previously ineligible for Medi-Cal may now be eligible for the Low-Income Health Program (LIHP) administered through DHCS. The two new programs within LIHP to be enacted in some California counties are:
 - Medicaid Coverage Expansion for adults 19 to 64 with family incomes up to 133 percent of FPL.
 - Health Care Coverage Initiative (HCCI) for adults 19 to 64 with family incomes from 134–200 percent of FPL.

Participation in these expansion programs is voluntary for the counties and there are some aspects that are left to each county's discretion. These are:

- Counties may choose to set the upper limit for income qualification to less than the 133 percent limit. If they do so, they will not be able to request funding from Medi-Cal for the HCCI program.

- All counties will have to comply with Medi-Cal cost-sharing limits, including those for prescription drugs. However, each county will have the discretion to charge lower per prescription drug co-pays or waive the charge entirely.

Some ADAP clients may be eligible for these programs in participating counties and this could generate savings in ADAP. OA is in the early stages of assessing potential impacts to ADAP and has started discussions with DHCS on the timing and extent of the 1115 waiver roll-out. OA will also need to work with its PBM to establish a system to verify eligibility for these new programs once it is confirmed that Ryan White funds would be considered a payer of last resort after these programs.

New Drugs that May be Available in the Next 3 Years

Possible approval in 2011

Rilpivirine

Rilpivirine is an investigational non-nucleoside reverse transcriptase inhibitors (NNRTI) in development for use with other ARV agents in treatment-naïve patients. This drug has shown activity against NNRTI-resistant HIV. Rilpivirine recently completed a Phase III clinical trial and the manufacturer submitted a New Drug Application (NDA) to the FDA on July 26, 2010. ADAP will monitor the scheduling of the review by the Antiviral Drugs Advisory Committee and potential FDA approval. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Truvada/Rilpivirine combination

Manufacturers are continuing development of a once-daily single-pill co-formulation of nucleoside/nucleotide reverse transcriptase inhibitor tenofovir and emtricitabine, the two drugs in the Truvada combination pill, plus rilpivirine. Gilead first applied for approval by the FDA in November, 2010. In January 2011, the FDA issued a refuse to file notice with questions surrounding formulation safety issues. Gilead has addressed these issues and re-applied. However, this activity has caused a delay in final approval. If approved by the FDA, the proposed Truvada/rilpivirine would become another option for a complete antiretroviral therapy available in a single pill. We are hopeful that pricing and supplemental rebate negotiations would result in price-neutrality with Atripla, the only other complete ARV therapy in a single pill. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Possible approval in late 2012 or early 2013

Combination elvitegravir, cobicistat, emtricitabine, and tenofovir (Quad)

As of September, 2010, a Phase II, 48 week study of an investigational fixed-dose, single-tablet "Quad" (four drugs) regimen of elvitegravir, cobicistat, emtricitabine and tenofovir was completed. The first Phase III study of the "Quad" versus Atripla was

recently fully enrolled, and the second study of the “Quad” versus a protease-based regimen is now fully enrolled. The results of these two studies are expected to be released in 2011. ADAP will monitor for filing of the NDA, Antiviral Drugs Advisory Committee scheduling, and potential FDA approval. It typically takes approximately six months from filing to approval for ARVs. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Elvitegravir

Elvitegravir is an investigational integrase inhibitor therapy that is in Phase III clinical trials. If approved, elvitegravir will offer a once-daily dosing option for integrase inhibitors, as compared to the currently available raltegravir, which requires dosing twice daily. Once FDA approved, there may be a shift from current raltegravir users to elvitegravir because of the reduced dosing requirement. In addition, patients may switch from once a day protease inhibitors (PI) and NNRTI once a daily integrase inhibitor is available. Assuming successful negotiations with the manufacturer by the ACTF, it is anticipated the net cost of elvitegravir (after rebates) will be comparable to raltegravir, which is comparable to once daily PIs and NNRTIs. This drug is also being studied as part of the previously discussed “Quad” formulation’s trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Cobicistat

Cobicistat is being developed both as a pharmacokinetic (PK) booster for integrase inhibitor elvitegravir and as a booster for protease inhibitors. The Phase II study compared efficacy and safety of cobicistat (150 mg) with that of existing booster ritonavir (100 mg daily). Participants are currently being sought for a Phase III clinical trial to further study cobicistat as a protease inhibitor booster. This drug is also being studied as part of the previously discussed “Quad” formulation’s trials which are in Phase III. If approved, ADAP will monitor pricing and supplemental rebate negotiations closely.

Possible approval in 2013

GSK1349572

Integrase inhibitor with activity against raltegravir-resistant HIV.

New Medications to Treat Hepatitis C Infection (HCV)

Telaprevir and boceprevir approvals are expected this summer for oral HCV treatment. As a result, there may be increased number or prescriptions for, although decreased duration of usage of, the other drugs on the ADAP formulary used to treat HCV and manage treatment-associated side effects. The Fair Pricing Coalition (FPC) has had meetings with both Merck and Vertex regarding pricing of the new oral agents for HCV. The FPC is pushing for cost neutrality, meaning that the new drug price when combined

with the current standard (interferon + ribavirin) will end up as the same cost for the current two drug treatment regimen, due to the shorter treatment period. This is an optimistic request but the FPC has made it clear that this will be the only way to get the new drugs on most ADAP formularies. Some are skeptical about a large utilization increase due to the even worse side effect profile of these new triple combination HCV treatment approaches. While the public WAC price probably won't meet the cost neutrality goal, the ACTF may be able to get special ADAP pricing that moves it closer to it. There may also be demand to add these agents to the ADAP formulary. Both Vertex and Merck seem to be moving toward good Patient Assistance Programs and co-pay assistance programs that could keep some of the pressure off of ADAPs to add.

TROFILE DNA assay

The tropism assay manufactured by Monogram BioSciences, Trofile ES, is currently FDA approved for use by physicians when determining the prescribing of maraviroc and is reimbursable through ADAP. Earlier this year Monogram BioSciences received approval for the *Trofile DNA* assay by the FDA. This assay is designed for use in patients with an undetectable HIV RNA level (viral load) who may want to use maraviroc due to side effects or other reasons. Both tests use the same current procedural terminology (CPT) code and bill for the same amount, \$1,575.75 plus a processing fee.

Since the Trofile DNA test would be used in a different patient population, this presents the possibility of minimally increased utilization of the tests and thus a small additional cost to ADAP. In-house monitoring of maraviroc usage in 2010 shows no increased utilization of the drug since the approval for use in treatment-naïve patients. ADAP is currently polling its Medical Advisory Committee (MAC) regarding their recommendations about the potential utility of this test in the clinical management of patients with HIV infection. Should it be added to ADAP, its use will be monitored closely. It is not expected to be used frequently.

APPENDIX D: CURRENT HIV/AIDS EPIDEMIOLOGY IN CALIFORNIA

HIV Prevalence

Prevalence reflects the number of people who are currently infected with HIV and thus who could qualify for ADAP currently or sometime in the future. California estimates that between 153,394 and 180,119 living with HIV/AIDS at the end of 2010, as seen in **Table 24**. This estimate includes people who are HIV positive but are not yet diagnosed (approximately 21 percent) by applying a national estimate of those unaware of their infection status that was developed by the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report, (MMWR, October 3, 2008). Living HIV/AIDS cases are estimated to be 46 percent White, 19 percent African American, 31 percent Latino, 3.6 percent Asian/Pacific Islander, and 0.4 percent American Indian/Alaskan Native. Most (65 percent) of California's living HIV/AIDS cases are attributed to male-to-male transmission, 8.3 percent is attributed to injection drug use, 9.3 percent to heterosexual transmission, and 8 percent to men who have sex with men who also practice injection drug use.

The number of living HIV/AIDS cases in the state is expected to grow by approximately 2 percent (with a range of 2,800–5,700) each year for the next two years and it is expected that this increasing trend will continue for the foreseeable future. This increase is attributed to stable incidence rates and longer survival of those infected (primarily due to the effectiveness and availability of treatment).

TABLE 24: ESTIMATED PERSONS LIVING WITH HIV IN CALIFORNIA, 2008-2012						
Year	Persons reported with HIV (not AIDS) and presumed living		Persons reported with AIDS and presumed living		Estimated persons living with HIV or AIDS*	
	Low bound	High bound	Low bound	High bound	Low bound	High bound
2008	43,230	56,223	66,884	66,884	148,160	167,908
2009	43,322	57,038	68,945	70,010	150,552	173,958
2010	43,427	57,840	71,318	72,824	153,302	179,649
2011	43,541	58,633	73,742	75,587	156,133	185,259
2012	43,660	59,421	76,193	78,324	159,012	190,822

*Includes persons unreported and/or persons unaware of their HIV infection.

HIV Incidence

Incidence is a measure of new infections over a specified period of time (typically a year) and thus provides an indication of the future need for ADAP support. Most people get tested infrequently, so incidence estimates largely rely on modeling. California estimates 5,000–7,000 new HIV infections annually. This estimate was developed through:

- A series of “consensus conferences” convened in California in 2000 that developed population estimates of HIV incidence; and
- Downward adjustment of the “consensus conference” estimate based upon observed reported HIV cases in the code-based HIV surveillance system; numbers observed to date in the names-based HIV surveillance system are consistent with this adjustment.

Recent advances have made estimation of HIV incidence possible using remnant blood samples from people found to be HIV antibody positive. In 2004, CDC began a national effort to measure incidence using state-of-the-art technology. Results of this effort were reported in the August 2008 issue of *Journal of the American Medical Association* and *MMWR*. California’s data were not included as they are not yet complete enough to provide accurate estimates. The 95 percent CI for the national estimate (48,200 to 64,500 new infections) is, however, consistent with the 5,000 to 7,000 range OA estimated for California in 2005 suggesting new HIV infections have been relatively steady in recent years.

California has implemented HIV Incidence Surveillance using the CDC-developed Serologic Testing Algorithm for Recent HIV Seroconversion methodology. Data from this system will be used to revise California incidence estimates in the coming years.

APPENDIX E: SENSITIVITY ANALYSIS

(Updated for May Revision)

FY 2010-11

ADAP conducted a sensitivity analysis exploring the impact on total expenditures by increasing and decreasing the number of clients and the expenditures per client (\$/client). For this sensitivity analysis, we started with the estimated total drug expenditures for FY 2010-11 using the upper bound of the 95 percent CI from the linear regression model and subtracted savings for the administration reduction in PBM contract costs and Medicare Part D TrOOP savings.

For these factors, clients and expenditures per client, we created scenarios ranging from negative 3 percent to positive 3 percent, in 1 percent intervals. Those scenarios labeled as “Hi” represent 3 percent, “Med” represent 2 percent, and “Lo” represents a 1 percent change. The left column in Table 25 below lists the seven (including no change) scenarios for changes in \$/client, starting with the best case scenario {3 percent decrease in \$/client, Hi(-)} and finishing with the worst case scenario {3 percent increase in \$/client, Hi(+)}. The seven scenarios for changes in client counts are listed across the table.

TABLE 25: SENSITIVITY ANALYSIS FOR FISCAL YEAR 2010-11 EXPENDITURES' ESTIMATE USING LINEAR REGRESSION MODEL							
\$ / Client Scenarios	Number of Client Scenarios						
	Hi (-) CI	Med (-) CI	Lo (-) CI	Zero Change in Clients	Lo (+) CI	Med (+) CI	Hi (+) CI
Hi (-): Best	\$432,332,392	\$436,725,314	\$441,118,236	\$445,511,158	\$449,904,080	\$454,297,002	\$458,689,924
Med (-)	\$436,725,314	\$441,163,524	\$445,601,734	\$450,039,944	\$454,478,154	\$458,916,364	\$463,354,573
Lo (-)	\$441,118,236	\$445,601,734	\$450,085,232	\$454,568,729	\$459,052,227	\$463,535,725	\$468,019,223
Zero Change in \$/ Client	\$445,511,158	\$450,039,944	\$454,568,729	\$459,097,515	\$463,626,301	\$468,155,086	\$472,683,872
Lo (+)	\$449,904,080	\$454,478,154	\$459,052,227	\$463,626,301	\$468,200,374	\$472,774,448	\$477,348,521
Med (+)	\$454,297,002	\$458,916,364	\$463,535,725	\$468,155,086	\$472,774,448	\$477,393,809	\$482,013,170
Hi (+): Worst	\$458,689,924	\$463,354,573	\$468,019,223	\$472,683,872	\$477,348,521	\$482,013,170	\$486,677,819

The center cell (**Table 25**), highlighted in light blue, shows the revised estimated expenditures for FY 2010-11, using the 95 percent CI from the linear regression model (less the administration reduction in PBM contract costs and Medicare Part D TrOOP savings). The best case scenario, which is a 3 percent decrease in \$/client coupled with a 3 percent decrease in the number of clients, results in an estimate of \$432,332,392 (top left cell, light green). The worst case scenario, a 3 percent increase in \$/client coupled with a 3 percent increase in number of clients, results in an estimate of \$486,677,819 (bottom right cell, red). The table provides a range of values to assist in projecting the total expenditures for FY 2010-11.

FY 2011-12

Below is the sensitivity analysis for FY 2011-12, using the same logic as above. In this Sensitivity Analysis, ADAP adjusted for several assumptions that impacted ADAP's FY 2011-12 total expenditures, non-approved transaction fees, and total client count. Similar to the FY 2010-11 Sensitivity Analysis, we started with the estimated total drug expenditures for FY 2011-12 using the upper bound of the 95 percent CI from the linear regression model. Then we subtracted savings for the PBM transaction fee savings, split savings, Medicare Part D TrOOP savings, and the RFP change in reimbursement rate for PBM contract, PCIP and CARE/HIPP expansion. The "baseline" or center cell, highlighted in light blue below, reflects all adjustments to the linear regression expenditure projection. **Table 26** provides a range of values to assist in projecting the total expenditures for FY 2011-12.

TABLE 26: SENSITIVITY ANALYSIS FOR FISCAL YEAR 2011-12 EXPENDITURES' ESTIMATE USING LINEAR REGRESSION MODEL							
\$ / Client Scenarios	Number of Client Scenarios						
	Hi (-) CI	Med (-) CI	Lo (-) CI	Zero Change in Clients	Lo (+) CI	Med (+) CI	Hi (+) CI
Hi (-): Best	\$473,980,892	\$478,845,467	\$483,710,041	\$488,574,616	\$493,439,191	\$498,303,765	\$503,168,340
Med (-)	\$478,845,467	\$483,760,192	\$488,674,917	\$493,589,641	\$498,504,366	\$503,419,091	\$508,333,816
Lo (-)	\$483,710,041	\$488,674,917	\$493,639,792	\$498,604,667	\$503,569,542	\$508,534,417	\$513,499,292
Zero Change in \$ / Client	\$488,574,616	\$493,589,641	\$498,604,667	\$503,619,692	\$508,634,717	\$513,649,743	\$518,664,768
Lo (+)	\$493,439,191	\$498,504,366	\$503,569,542	\$508,634,717	\$513,699,893	\$518,765,068	\$523,830,244
Med (+)	\$498,303,765	\$503,419,091	\$508,534,417	\$513,649,743	\$518,765,068	\$523,880,394	\$528,995,720
Hi (+): Worst	\$503,168,340	\$508,333,816	\$513,499,292	\$518,664,768	\$523,830,244	\$528,995,720	\$534,161,196